


ARKANSAS CODE OF 1987 ANNOTATED

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ARKANSAS CODE OF 1987 ANNOTATED



VOLUME 20A 2018 Replacement TITLE 20: PUBLIC HEALTH AND WELFARE (CHAPTERS 1-16)

Prepared by the Editorial Staff of the Publisher

Under the Direction and Supervision of the
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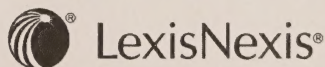
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Sources

This volume contains legislation enacted by the Arkansas General Assembly through the 2018 Fiscal Session and the 2018 Second Extraordinary Session. Annotations are to the following sources:

Arkansas Supreme Court and Arkansas Court of Appeals Opinions
Federal Supplement
Federal Reporter
United States Supreme Court Reports
Bankruptcy Reporter
Arkansas Law Notes
Arkansas Law Review
University of Arkansas at Little Rock Law Review
American Law Reports (ALR)

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Businesses |
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User's Guide

Differences in language, subsection order, punctuation, and other variations in the statute text from legislative acts, supplement pamphlets, and previous versions of the bound volume are editorial changes made at the direction of the Arkansas Code Revision Commission pursuant to the authority granted in § 1-2-303.

Many of the Arkansas Code's research aids, as well as its organization and other features, are described in the User's Guide, which appears near the beginning of the bound Volume 1A of the Code.

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PUBLIC HEALTH AND WELFARE

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20-2-106. [Repealed.]
 20-2-107. Report on health disparities.

Publisher's Notes. Former §§ 20-2-101 — 20-2-103, concerning the Arkansas Commission on Human Resources, were repealed by Acts 1991, No. 343, § 9. The sections were derived from:

20-2-101. Acts 1977, No. 954, § 1; A.S.A. 1947, § 6-1501.

20-2-102. Acts 1977, No. 954, § 2; 1983, No. 752, § 1; A.S.A. 1947, § 6-1502.

20-2-103. Acts 1977, No. 954, § 3; 1983, No. 752, § 2; A.S.A. 1947, § 6-1503.

Former § 20-2-104, concerning the Arkansas Commission on Human Resources, was repealed by Acts 1991, No. 343, § 9. The section was derived from Acts 1977, No. 954, § 4; A.S.A. 1947, § 6-1504.

Former § 20-2-105, concerning the Arkansas Commission on Human Resources, was repealed by Acts 1991, No. 343, § 9. The section was derived from Acts 1977, No. 954, § 5; A.S.A. 1947, § 6-1505.

Effective Dates. Acts 1995, No. 1017, § 9: July 1, 1995. Emergency clause provided: "It is hereby found and determined by the Eightieth General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness of this Act on July 1, 1995 is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1, 1995 could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 1995."

Acts 1997, No. 250, § 258: Feb. 24, 1997. Emergency clause provided: "It is hereby found and determined by the General Assembly that Act 1211 of 1995 established the procedure for all state boards and commissions to follow regarding reimbursement of expenses and stipends for board members; that this act amends

various sections of the Arkansas Code which are in conflict with the Act 1211 of 1995; and that until this cleanup act becomes effective conflicting laws will exist. Therefore an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 2003, No. 229, § 6: July 1, 2003. Emergency clause provided: "It is found and determined by the General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness of this Act on July 1, 2003 is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1, 2003 could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 2003."

Acts 2005, No. 1405, § 5: July 1, 2005. Emergency clause provided: "It is found and determined by the General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness of this Act on July 1, 2005 is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1, 2005 could work ir-

reparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and

this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 2005.”

20-2-101. Definitions.

As used in this subchapter:

(1) “Commission” means the Arkansas Minority Health Commission; and

(2) “Minority” means black Americans, Hispanic Americans, Asian Americans, and American Indians.

History. Acts 1991, No. 912, § 1.

20-2-102. Creation — Members.

(a) There is established the Arkansas Minority Health Commission to consist of twelve (12) members to be appointed as follows:

(1) Six (6) members of the general public to be appointed by the Governor, with each of the four (4) congressional districts represented;

(2) Three (3) members to be appointed by the President Pro Tempore of the Senate; and

(3) Three (3) members to be appointed by the Speaker of the House of Representatives.

(b) All persons appointed to the commission shall be persons who have actively participated in health issues for minorities or have special knowledge or experience with minority health issues.

(c) The members shall serve staggered two-year terms.

(d)(1) The commission shall meet at least quarterly and at such other times as necessary to carry out its duties under this chapter.

(2) The commission shall elect one (1) of its members as chair and may provide by appropriate adoption of bylaws and rules for the time, place, and manner of calling its meetings.

(e) Any state agency, state-supported hospital, or state medical school shall submit to the commission any information the commission requests that relates to health issues for minorities except for names, addresses, telephone numbers, or any other identifying information.

History. Acts 1991, No. 912, §§ 2, 4, 5; § 15; 2007, No. 827, § 144; 2009, No. 574, 1997, No. 250, § 176; 2001, No. 1288, § 1.

20-2-103. Powers and duties generally.

(a) The Arkansas Minority Health Commission shall:

(1) Establish the commission as the comprehensive agency in this state for:

(A) Gathering and analyzing information regarding disparities in health and health care and access to health and healthcare services in this state;

(B) Statewide educational programming regarding disparities in health and health care and equal access to health and healthcare services; and

(C) Coordinating events regarding disparities in health and health care and access to health and healthcare services;

(2)(A) Actively seek out and develop partnerships and collaboration with other appropriate organizations to advance the understanding of and access to programs to remediate disparities in health and health care and access to health and healthcare services in this state.

(B) The following health and healthcare-related state agencies and divisions of state agencies shall collaborate with the commission to achieve healthcare equity in the State of Arkansas:

(i) The Department of Health;

(ii) The Department of Human Services;

(iii) The Arkansas Department of Environmental Quality;

(iv) The Fay W. Boozman College of Public Health of the University of Arkansas for Medical Sciences; and

(v) The Arkansas Center for Health Improvement.

(C) Partnerships developed by the commission shall connect all experts, agencies, and organizations concerned with minority health issues and minority health events;

(3) Address and make specific recommendations relating to public policy issues involving disparities in health and health care and equity to health and healthcare services for minorities to appropriate agencies, the General Assembly, and the Governor;

(4) Promote public awareness and public education encouraging Arkansans to live healthy lifestyles through awareness of various health and healthcare issues with an emphasis on factors that disproportionately affect the minority population in this state;

(5) Make recommendations to the relevant agencies, to the Governor, and to the General Assembly for improving the delivery of and access to health services for minorities;

(6) Gather and analyze information and make recommendations as to whether adequate services are available to ensure that future minority health needs will be met;

(7)(A) Develop, implement, maintain, and disseminate a comprehensive survey of racial and ethnic minority disparities in health and health care.

(B) The commission shall repeat the study every five (5) years to include without limitation disparities arising from geographic location and economic conditions; and

(8) Publish evidence-based data, define state goals and objectives, and develop pilot projects for decreasing disparities under subdivision (a)(7)(A) of this section.

(b) The commission shall report two (2) times each year to the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor.

History. Acts 1991, No. 912, § 3; 2009, No. 358, § 1; 2009, No. 574, § 1; 2013, No. 1132, § 1.

Amendments. The 2013 amendment substituted “equal access” for “equity” in (a)(1)(B).

20-2-104. Reimbursement for expenses.

(a) Members of the Arkansas Minority Health Commission shall serve without pay, but those members not employed by the State of Arkansas may receive expense reimbursement in accordance with § 25-16-901 et seq.

(b) The commission may authorize expense reimbursement for its members performing official duties of the commission by a majority vote of its total membership cast at its first regularly scheduled meeting of each calendar year.

(c) Any expense reimbursement shall not exceed the rate established for state employees in the state travel regulations.

History. Acts 1995, No. 1017, § 3; 1997, No. 250, § 177; 2003, No. 229, § 3; 2007, No. 827, § 145.

20-2-105. Cash fund.

(a) There is created a cash fund entitled “Minority Health Commission Cash Fund” to be used for expenses of the Arkansas Minority Health Commission as appropriated by the General Assembly.

(b) The commission may receive grants and donations made to the commission or amounts received as reimbursement for producing or reproducing literature or reports, which shall be deposited into the State Treasury as cash funds and may be used for reimbursements for expenses of providing seminars or educational activities.

History. Acts 2005, No. 1405, § 2.

20-2-106. [Repealed.]

Publisher’s Notes. This section, concerning the Arkansas Commission on Human Resources, was repealed by Acts 1991, No. 343, § 9. The section was derived from Acts 1977, No. 954, § 5; A.S.A. 1947, § 6-1505.

20-2-107. Report on health disparities.

On or before October 1 each year, the Arkansas Minority Health Commission shall report to the Governor, the Speaker of the House of Representatives, the President Pro Tempore of the Senate, the Chair of the House Committee on Public Health, Welfare, and Labor, and the Chair of the Senate Committee on Public Health, Welfare, and Labor without limitation:

(1) Summarizing the previous year’s work under § 20-2-103(a)(5) and (6);

(2) Describing reductions in disparities in health and health care in this state; and

(3) Outlining plans for continuing and expanding in the coming year the program to reduce disparities in health and health care in this state.

History. Acts 2009, No. 358, § 2.

CHAPTER 3
ACHIEVING A BETTER LIFE EXPERIENCE PROGRAM
ACT

SECTION.	SECTION.
20-3-101. Title.	20-3-106. Rules.
20-3-102. Purpose.	20-3-107. Investment direction.
20-3-103. Definitions.	20-3-108. ABLE accounts.
20-3-104. Creation of Achieving a Better Life Experience Program Trust.	20-3-109. Naming of designated beneficiary and transfers of ABLE accounts.
20-3-105. Achieving a Better Life Experience Program Committee — Administration — Authority — Powers.	20-3-110. Prohibitions.
	20-3-111. Funds exempt from tax.
	20-3-112. Limitation on liability.
	20-3-113. Liberal construction.

A.C.R.C. Notes. Acts 2015, No. 1238, § 2, provided: “The Achieving a Better Life Experience Program becomes effective when the Treasurer of State determines that federal regulations regarding the Achieving a Better Life Experience Program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295, have been finalized and provide the guidance necessary to implement the achieving a Better Life Experience Program.”

Effective Dates. Acts 2017, No. 324, § 2: Mar. 2, 2017. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act requires program changes by the Treasurer of State; that the immediate effectiveness of this act is

essential to the operations of the office of the Treasurer of State; and that this act is immediately necessary because delay in the effective date of this act could work irreparable harm upon the proper administration and provision of essential programs of the office of the Treasurer of State. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

20-3-101. Title.

This chapter shall be known and may be cited as the “Achieving a Better Life Experience Program Act”.

History. Acts 2015, No. 1238, § 1.

20-3-102. Purpose.

It is the intent and purpose of this chapter to create and establish the Achieving a Better Life Experience Program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295.

History. Acts 2015, No. 1238, § 1.

U.S.C. § 529A, amended 26 U.S.C.

U.S. Code. Division B, Title I of the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295, concerns qualified ABLE programs. Division B, Title I enacted 26

§§ 529, 4973, 6693; 5 U.S.C. § 552a; and 11 U.S.C. §§ 521, 541, 707, and made conforming amendments.

20-3-103. Definitions.

As used in this chapter:

(1) “ABLE account” means an account:

- (A) Established by an eligible individual;
- (B) Owned by the eligible individual; and
- (C) Maintained under this subchapter;

(2) “Contracting state” means a state without a qualified ABLE program that has entered into a contract with Arkansas to provide residents of the contracting state access to a qualified ABLE program;

(3) “Designated beneficiary” means the eligible individual who established an ABLE account and is the owner of the ABLE account;

(4) “Disability certification” means, with respect to an individual, a certification to the satisfaction of the United States Secretary of the Treasury by the individual or the parent or guardian of the individual that:

(A) Certifies that:

(i)(a)(1) The individual has a medically determinable physical or mental impairment that:

- (A) Results in marked and severe functional limitations; and
- (B) Can be expected to result in death; or

(2) Has lasted or can be expected to last for a continuous period of not less than twelve (12) months; or

(b) The individual is blind within the meaning of § 1614(a)(2) of the Social Security Act; and

(ii) The blindness or disability occurred before the individual attained twenty-six (26) years of age; and

(B) Includes a copy of the individual’s diagnosis relating to the individual’s relevant impairment or impairments, signed by a physician meeting the criteria of § 1861(r)(1) of the Social Security Act;

(5) “Eligible individual” means an individual who for a taxable year:

(A) Is entitled to benefits based on blindness or disability under Title II or Title XVI of the Social Security Act, 42 U.S.C. § 301 et seq., and the blindness or disability is a preexisting condition that occurred before the date on which the individual attained twenty-six (26) years of age; or

(B) Has a disability certification filed with the United States Secretary of the Treasury for the taxable year;

(6) “Member of the family” means a brother, sister, stepbrother, or stepsister;

(7) “Nonqualified distribution” means a distribution from an ABLE account that is not used to pay a qualified disability expense; and

(8) “Qualified disability expense” means an expense related to an eligible individual’s blindness or disability that is made for the benefit of the eligible individual who is the designated beneficiary, including without limitation the following expenses:

- (A) Assistive technology and personal support services;
- (B) Education;
- (C) Employment training and support;
- (D) Expenses for oversight and monitoring;
- (E) Financial management and administrative services;
- (F) Funeral and burial expenses;
- (G) Health, prevention, and wellness expenses;
- (H) Housing;
- (I) Legal fees;
- (J) Transportation; and

(K) Other expenses that are adopted by rule and consistent with the purposes of this chapter.

History. Acts 2015, No. 1238, § 1.

U.S. Code. Section 1614(a)(2) of the Social Security Act, referred to in this section, is codified as 42 U.S.C. § 1382c(a)(2).

Section 1861(r)(1) of the Social Security Act is codified as 42 U.S.C. § 1395x(r)(1). Titles II and XVI of the Social Security Act are codified as 42 U.S.C. § 401 et seq., and 42 U.S.C. § 1381 et seq., respectively.

20-3-104. Creation of Achieving a Better Life Experience Program Trust.

(a) The Achieving a Better Life Experience Program Trust is created.

(b) The cotrustees of the trust shall be the Director of the Department of Human Services, the Director of Arkansas Rehabilitation Services, and the Treasurer of State.

History. Acts 2015, No. 1238, § 1.

20-3-105. Achieving a Better Life Experience Program Committee — Administration — Authority — Powers.

(a) This chapter shall be administered by the Achieving a Better Life Experience Program Committee, which shall be composed of:

(1) The Director of the Department of Human Services, or his or her designee;

(2) The Director of Arkansas Rehabilitation Services of the Department of Career Education, or his or her designee; and

(3) The Treasurer of State, or his or her designee.

(b) The Treasurer of State shall:

(1) Manage the Achieving a Better Life Experience Program Trust under § 20-3-104 for the committee;

(2) Provide office space, staff, and materials for the committee;
 (3) Perform other services necessary to implement this chapter; and
 (4) Conduct outreach and engage in financial educational activities with individuals with disabilities, stakeholders within the community of individuals with disabilities, and their support system.

(c) The committee shall adopt rules necessary to administer this chapter and to ensure compliance with the Achieving a Better Life Experience Program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295 and federal regulations under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295.

(d) The committee shall:

(1) Establish, develop, implement, and maintain the Achieving a Better Life Experience Program in a manner consistent with this chapter and the Achieving a Better Life Experience Program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295, and obtain the benefits provided by the Achieving a Better Life Experience Program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295, for the program, account owners, and designated beneficiaries;

(2) Adopt rules for the general administration of the program;

(3) Maintain, invest, and reinvest the funds contributed into the program consistent with the investment restrictions established by the committee and the standard of care described in the prudent investor rule under § 24-2-611; and

(4)(A) Make and enter into contracts, agreements, or arrangements and retain, employ, and contract for the services of financial institutions, depositories, consultants, broker-dealers, investment advisors or managers, third-party plan administrators, and research, technical, and other services necessary or desirable for carrying out the purposes of this chapter.

(B) Contracts entered into by the committee may be for a term of one to ten (1-10) years.

History. Acts 2015, No. 1238, § 1; 2017, No. 324, § 1.

Amendments. The 2017 amendment rewrote (b).

U.S. Code. Division B, Title I of the Tax Increase Prevention Act of 2014, Pub.

L. No. 113-295, concerns qualified ABLE programs. Division B, Title I enacted 26 U.S.C. § 529A, amended 26 U.S.C. §§ 529, 4973, 6693; 5 U.S.C. § 552a; and 11 U.S.C. §§ 521, 541, 707, and made conforming amendments.

20-3-106. Rules.

Rules adopted under this chapter shall ensure that:

(1)(A) A rollover from an ABLE account does not apply to an amount paid or distributed from the ABLE account to the extent that, not later than the sixtieth day after the date of the payment or distribution, the amount received is paid into another ABLE account for the benefit of the same designated beneficiary or an eligible individual who is a member of the family of the designated beneficiary; and

(B) The limitation under subdivision (1)(A) of this section does not apply to a transfer if the transfer occurs within twelve (12) months after the date of a previous transfer under this chapter for the benefit of the designated beneficiary;

(2) A person may make contributions for a taxable year for the benefit of an individual who is an eligible individual for the taxable year to an ABLE account that is established to meet the qualified disability expenses of the designated beneficiary of the ABLE account;

(3) A designated beneficiary is limited to one (1) ABLE account;

(4) An ABLE account may be established only for a designated beneficiary who is a resident of Arkansas or a resident of a contracting state; and

(5) Other requirements of this chapter shall be met.

History. Acts 2015, No. 1238, § 1.

20-3-107. Investment direction.

Except as permitted under the Achieving a Better Life Experience Program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295, a person shall not direct the investment of any contributions to or earnings from the program more than two (2) times each year.

History. Acts 2015, No. 1238, § 1.

U.S. Code. Division B, Title I of the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295, concerns qualified ABLE programs. Division B, Title I enacted 26

U.S.C. § 529A, amended 26 U.S.C. §§ 529, 4973, 6693; 5 U.S.C. § 552a; and 11 U.S.C. §§ 521, 541, 707, and made conforming amendments.

20-3-108. ABLE accounts.

(a)(1) An account owner or contributor may establish an ABLE account by making an initial contribution to the Achieving a Better Life Experience Program, signing an application form approved by the Achieving a Better Life Experience Program Committee, and naming the ABLE account owner and the designated beneficiary.

(2) If the contributor is not the ABLE account owner, the ABLE account owner shall also sign the application form.

(3) Any person may make contributions to an ABLE account after the ABLE account is opened.

(b) Contributions to an ABLE account shall be made only in cash.

(c)(1) Total contributions to all ABLE accounts shall not exceed those reasonably necessary to provide for the qualified disability expenses of the beneficiary.

(2) The committee shall establish maximum contribution limits applicable to program ABLE accounts in accordance with the program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295.

(d)(1) Separate records and accounting shall be required by the program for each ABLE account.

(2) Reports shall be made no less frequently than annually to the ABLE account owner.

(e)(1) The program may collect application, ABLE account, or administrative fees to defray the costs of the program.

(2) The application, ABLE account, or administrative fees shall be approved by the committee.

History. Acts 2015, No. 1238, § 1.

U.S. Code. Division B, Title I of the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295, concerns qualified ABLE programs. Division B, Title I enacted 26

U.S.C. § 529A, amended 26 U.S.C. §§ 529, 4973, 6693; 5 U.S.C. § 552a; and 11 U.S.C. §§ 521, 541, 707, and made conforming amendments.

20-3-109. Naming of designated beneficiary and transfers of ABLE accounts.

(a) An ABLE account owner shall have the right to name the designated beneficiary of an ABLE account and at any time to change the designated beneficiary of an ABLE account to an eligible individual who is a member of the family of the former designated beneficiary.

(b) At the direction of an ABLE account owner, all or a portion of an ABLE account may be transferred to another ABLE account of which the designated beneficiary is a member of the family of the designated beneficiary of the transferee ABLE account if the transferee ABLE account was created by this chapter or in accordance with the Achieving a Better Life Experience Program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295.

History. Acts 2015, No. 1238, § 1.

U.S. Code. Division B, Title I of the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295, concerns qualified ABLE programs. Division B, Title I enacted 26

U.S.C. § 529A, amended 26 U.S.C. §§ 529, 4973, 6693; 5 U.S.C. § 552a; and 11 U.S.C. §§ 521, 541, 707, and made conforming amendments.

20-3-110. Prohibitions.

(a) Total contributions to the ABLE account established on behalf of a particular designated beneficiary in excess of those reasonably necessary to meet the designated beneficiary's qualified disability expenses are prohibited.

(b)(1) An ABLE account or a legal or beneficial interest in an ABLE account shall not be assignable, pledged, or otherwise used to secure or obtain a loan or other advancement.

(2) An ABLE account or a legal or beneficial interest in an ABLE account is not subject to attachment, levy, or execution by a creditor of an ABLE account owner or designated beneficiary.

History. Acts 2015, No. 1238, § 1.

20-3-111. Funds exempt from tax.

(a) Except as otherwise indicated in this chapter, interest, dividends, and capital gains from funds invested in the Achieving a Better Life Experience Program are exempt from Arkansas income taxes.

(b)(1) A qualified distribution from a disability savings account established under the program is exempt from Arkansas income tax with respect to the designated beneficiary's income.

(2)(A) Nonqualified distributions from a disability savings account established under the program are subject to Arkansas income tax.

(B) The nonqualified distribution is taxable to the party, account owner, or designated beneficiary who actually makes the withdrawal.

(c) Earnings on a contribution that are included in a refund are subject to Arkansas income tax if an account owner receives a refund of contributions to a disability savings account established under the program because of either:

(1) The death or disability of the designated beneficiary; or

(2) A scholarship, allowance, or payment described in 26 U.S.C. § 135(d)(1)(B) or (d)(1)(C) as in effect on January 1, 2014, received by the designated beneficiary.

History. Acts 2015, No. 1238, § 1.

20-3-112. Limitation on liability.

Neither the Achieving a Better Life Experience Program, the Achieving a Better Life Experience Program Committee and each of its members, nor the state shall:

(1) Insure any ABLE account or guarantee any rate of return or any interest rate on any contribution;

(2) Be liable for any loss incurred by any person as a result of participating in the program under this chapter; or

(3) Be deemed to be a guarantor of a positive return on a contribution under this chapter.

History. Acts 2015, No. 1238, § 1.

20-3-113. Liberal construction.

This chapter shall be liberally construed to comply with the requirements of the Achieving a Better Life Experience Program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295.

History. Acts 2015, No. 1238, § 1.

U.S. Code. Division B, Title I of the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295, concerns qualified ABLE programs. Division B, Title I enacted 26

U.S.C. § 529A, amended 26 U.S.C. §§ 529, 4973, 6693; 5 U.S.C. § 552a; and 11 U.S.C. §§ 521, 541, 707, and made conforming amendments.

CHAPTERS 4-5

[Reserved.]

SUBTITLE 2. HEALTH AND SAFETY

CHAPTER 6

GENERAL PROVISIONS

SUBCHAPTER.

- 1. ARKANSAS HEALTHCARE DECISIONS ACT.
- 2. PATIENT RIGHT-TO-KNOW ACT.
- 3. ARKANSAS PHYSICIAN ORDER FOR LIFE-SUSTAINING TREATMENT ACT.

SUBCHAPTER 1 — ARKANSAS HEALTHCARE DECISIONS ACT

SECTION.

- 20-6-101. Title.
- 20-6-102. Definitions.
- 20-6-103. Oral or written individual instructions — Advance directive for health care — When effective — Decisions based on best interest assessment — Out-of-state directives — Construction.
- 20-6-104. Revocation of designation of agent — Revocation of advance directive — Spouse as agent — Conflicts.
- 20-6-105. Designation of surrogate.
- 20-6-106. Authority of surrogate.
- 20-6-107. Requirement of guardian to comply with principal's individual instruction.
- 20-6-108. Determination of capacity.

SECTION.

- 20-6-109. Compliance by healthcare provider or institution.
- 20-6-110. Disclosure of medical or other healthcare information.
- 20-6-111. Liability.
- 20-6-112. Presumption of capacity.
- 20-6-113. Copies have same effect as originals.
- 20-6-114. Presumptions not created — Death that results from withholding or withdrawal of health care does not constitute suicide, euthanasia, homicide, mercy killing, or assisted suicide.
- 20-6-115. Court jurisdiction.
- 20-6-116. Effect and interpretation of living wills.
- 20-6-117. Effect and interpretation of durable powers of attorney.
- 20-6-118. [Repealed.]

A.C.R.C. Notes. Acts 2013, No. 1264, § 2, provided: "The State Board of Health shall adopt the following forms and may by rule revise the forms so long as the

revisions are consistent with the intent of this act."

FORMS

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (**you can check as many of these items as you want**):

- ☐ **Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
- ☐ **Permanent Confusion:** I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- ☐ **Dependent in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- ☐ **End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. **Checking “yes” means I WANT the treatment. Checking “no” means I DO NOT want the treatment.**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Life Support / Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tube feeding/IV fluids: Use of tubes to deliver food and water to patient’s stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other instructions, such as burial arrangements, hospice care, etc.: _____

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: _____
(Patient)

DATE: _____

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF ARKANSAS
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

APPOINTMENT OF HEALTH CARE AGENT
(Arkansas)

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:

Alternate:

Name

Name

Address

Address

City State Zip Code

City State Zip Code

()
Area Code Home Phone Number

()
Area Code Home Phone Number

()
Area Code Work Phone Number

()
Area Code Work Phone Number

()
Area Code Mobile Phone Number

()
Area Code Mobile Phone Number

Patient's name (please print or type) Date

Signature of patient (must be at least 18 or emancipated minor)

To be legally valid, **either** block A or block B must be properly completed and signed.

Block A Witnesses (2 witnesses required)

1. I am a competent adult who is not named above.
I witnessed the patient's signature on this form.

Signature of witness number 1

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

Signature of witness number 2

Block B Notarization

STATE OF ARKANSAS
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

Signature of Notary Public

ACCEPTANCE OF SURROGATE SECTION

I accept the appointment as surrogate for _____ Patient

and understand I have the authority to make all medical decisions.

Signature of Surrogate

Date/Time

20-6-101. Title.

This subchapter shall be known and may be cited as the “Arkansas Healthcare Decisions Act”.

History. Acts 2013, No. 1264, § 1.

20-6-102. Definitions.

As used in this subchapter:

(1) “Advance directive” means an individual instruction or a written statement that anticipates and directs the provision of health care for an individual, including without limitation a living will or a durable power of attorney for health care;

(2) “Agent” means an individual designated in an advance directive to make a healthcare decision for the individual granting the power;

(3) “Capacity” means an individual’s ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a healthcare decision;

(4)(A) “Durable power of attorney for health care” means a written advance directive that identifies an agent who is authorized to make healthcare decisions on behalf of the principal.

(B) “Durable power of attorney for health care” includes without limitation a document appointing a healthcare proxy executed under § 20-17-202;

(5) “Emancipated minor” means a minor who has been emancipated under § 9-27-362;

(6) “Emergency responder” means a paid or volunteer firefighter, law enforcement officer, or other public safety official or volunteer acting within the scope of his or her proper function or rendering emergency care at the scene of an emergency;

(7) “Guardian” means a judicially appointed guardian or conservator having authority to make a healthcare decision for an individual;

(8) “Health care” means any care, treatment, service, or procedure to maintain, diagnose, treat, or otherwise affect an individual’s physical or mental condition, including medical care;

(9) “Healthcare decision” means consent, refusal of consent, or withdrawal of consent to health care;

(10)(A) “Healthcare institution” means an agency, institution, facility, or place, whether publicly or privately owned or operated, that provides healthcare services, medical treatment, or nursing or rehabilitative care to a person.

(B) “Healthcare institution” includes without limitation:

- (i) An ambulatory surgical facility;
- (ii) A birthing center;
- (iii) A home health agency;
- (iv) A hospital;
- (v) An intermediate care facility for individuals with intellectual disabilities;
- (vi) A mental health center;
- (vii) An assisted living facility;
- (viii) A nursing home;
- (ix) An outpatient diagnostic center;
- (x) A residential treatment facility;
- (xi) A rehabilitation facility; and
- (xii) A hospice;

(11) “Healthcare provider” means a person who is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of the practice of his or her profession;

(12) “Individual instruction” means an individual’s direction concerning a healthcare decision for the individual;

(13)(A) “Living will” means a written advance directive describing the principal’s individual instructions for health care to be provided or withheld if the principal subsequently lacks decision-making capacity.

(B) “Living will” includes without limitation a declaration executed under § 20-17-202;

(14) “Medical care” means the diagnosis, cure, mitigation, treatment, or prevention of disease for the purpose of affecting any structure or function of the body;

(15) “Person” means an individual, corporation, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency, instrumentality, or any other legal or commercial entity;

(16) “Person authorized to consent on the principal’s behalf” means:

(A) A person authorized by law to consent on behalf of the principal when the principal is incapable of making an informed decision; or

(B) In the case of a minor child, the parent or parents having custody of the child, the child’s legal guardian, or another person as otherwise provided by law;

(17) “Personally inform” means to communicate by any effective means from the principal directly to a healthcare provider;

(18) “Physician” means an individual authorized to practice medicine or osteopathy in this state;

(19) “Principal” means an individual who grants authority to another individual under this subchapter;

(20) “Qualified emergency medical service personnel” includes without limitation emergency medical technicians, paramedics, or other emergency services personnel, providers, or entities acting within the usual course of their professions, and other emergency responders;

(21) “Reasonably available” means readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the principal’s healthcare needs, including without limitation availability by telephone;

(22) “State” means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States;

(23) “Supervising healthcare provider” means a licensed physician or other authorized independent healthcare provider who has undertaken primary responsibility for an individual’s health care;

(24) “Surrogate” means an individual, other than a principal’s agent or guardian, authorized under this subchapter to make a healthcare decision for the principal; and

(25) “Treating healthcare provider” means a healthcare provider who is directly or indirectly involved in providing health care to the principal.

History. Acts 2013, No. 1264, § 1; 2017, No. 974, § 1.

Amendments. The 2017 amendment deleted former (4), (17), and (25) and inserted the definitions for “Durable power of attorney for health care”, “Emancipated minor”, and “Living will” and redesignated the remaining subdivisions accordingly; deleted “for health care” following

“directive” in (2); rewrote (10); substituted “another individual” for “an individual” in (19); and substituted “a licensed physician or other authorized independent” for “the designated physician or, if there is no designated physician or the designated physician is not reasonably available, the” in (23).

20-6-103. Oral or written individual instructions — Advance directive for health care — When effective — Decisions based on best interest assessment — Out-of-state directives — Construction.

(a)(1)(A) An adult, married minor, or emancipated minor may make healthcare decisions for himself or herself and give an individual instruction.

(B) A person who is authorized to consent on behalf of a principal may make healthcare decisions for the principal and may give an individual instruction.

(2) The instruction may be oral or written.

(3) The instruction may be limited to take effect only if a specified condition arises.

(b)(1) An adult, married minor, or emancipated minor may execute a durable power of attorney for health care that authorizes an agent to make a healthcare decision that the principal could make if he or she had capacity.

(2) A durable power of attorney for health care shall be in writing and signed by the principal.

(3) A durable power of attorney for health care remains in effect notwithstanding the principal's latest incapacity and may include a living will or other individual instructions.

(c)(1) An advance directive, including without limitation a living will or durable power of attorney for health care, shall be either notarized or witnessed by two (2) witnesses.

(2) For the purposes of this subsection, a witness shall be a competent adult who is not the agent, and at least one (1) of the witnesses is not related to the principal by blood, marriage, or adoption and would not be entitled to any portion of the estate of the principal upon the death of the principal under any will or codicil made by the principal existing at the time of execution of the advance directive or by operation of law.

(3) A written advance directive, including without limitation a living will or durable power of attorney for health care, that is witnessed shall contain an attestation clause that attests that the witnesses comply with this subsection.

(4) A written advance directive may include the principal's nomination of a guardian of the principal.

(d) Unless otherwise specified in an advance directive, the authority of an agent becomes effective only upon a determination that the principal lacks capacity and ceases to be effective upon a determination that the principal has recovered capacity.

(e)(1) If necessary, a licensed physician shall determine whether a principal lacks or has recovered capacity or that another condition exists that affects an individual instruction or the authority of an agent.

(2) In making a determination under subdivision (e)(1) of this section, a licensed physician may consult with other persons as he or she deems appropriate.

(f)(1) An agent shall make a healthcare decision in accordance with the principal's individual instructions and other wishes to the extent known to the agent.

(2)(A) In the absence of individual instructions or other information, the agent shall make the decision in accordance with the agent's determination of the principal's best interest.

(B) In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

(g) A healthcare decision made by an agent for a principal is effective without judicial approval.

(h) An advance directive that is executed outside of this state shall be given effect in this state if, at the time of execution, the advance

directive complies with either this subchapter or the laws of the state in which the advance directive was executed.

(i) A healthcare provider, healthcare institution, healthcare service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital plan shall not require the execution or revocation of an advance directive as a condition of the principal's being insured for or receiving health care.

History. Acts 2013, No. 1264, § 1; 2017, No. 974, § 1.

Amendments. The 2017 amendment rewrote the section.

20-6-104. Revocation of designation of agent — Revocation of advance directive — Spouse as agent — Conflicts.

(a) A principal having capacity may revoke all or part of an advance directive, including without limitation a living will, durable power of attorney for health care, or other document, at any time and in any manner that communicates an intent to revoke.

(b) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as agent unless otherwise specified in the decree or in an advance directive.

(c) An advance directive that conflicts with an earlier advance directive revokes the earlier advance directive to the extent of the conflict.

(d) A healthcare provider, agent, guardian, or surrogate who is informed of a revocation shall promptly communicate the fact of the revocation to the supervising healthcare provider and any healthcare institution at which the patient is receiving care.

History. Acts 2013, No. 1264, § 1; 2017, No. 974, § 1.

Amendments. The 2017 amendment substituted “including without limitation a living will, durable power of attorney for

health care, or other document” for “other than the designation of an agent” in (a); deleted former (b) and redesignated the remaining subsections accordingly; and added (d).

20-6-105. Designation of surrogate.

(a)(1) An adult, married minor, or emancipated minor may designate an individual to act as surrogate by personally informing the supervising healthcare provider.

(2) The designation may be oral or written.

(b) A surrogate may make a healthcare decision for a principal who is an adult or emancipated minor only if:

(1) The principal has been determined by a licensed physician to lack capacity; and

(2) An agent or guardian has not been appointed or the agent or guardian is not reasonably available.

(c)(1) The supervising healthcare provider shall identify a surrogate for the principal and document the appointment in the clinical record of the institution or institutions at which the principal is receiving health care if the principal:

- (A) Lacks capacity;
- (B) Has not appointed an agent or the agent is not reasonably available;
- (C) Has not designated a surrogate or the surrogate is not reasonably available; and
- (D) Does not have a guardian or the guardian is not reasonably available.

(2)(A) The principal's surrogate shall be an adult who:

- (i) Has exhibited special care and concern for the principal;
- (ii) Is familiar with the principal's personal values;
- (iii) Is reasonably available; and
- (iv) Is willing to serve.

(B) A person who is the subject of a protective order or other court order that directs that person to avoid contact with the principal is not eligible to serve as the principal's surrogate.

(3) In identifying the person best qualified to serve as the surrogate for the principal, the supervising healthcare provider:

(A) Shall consider the proposed surrogate's:

(i) Ability to make decisions either in accordance with the known wishes of the principal or in accordance with the principal's best interests;

(ii) Frequency of contact with the principal before and during the incapacitating illness; and

(iii) Demonstrated care and concern; and

(B) May consider the proposed surrogate's:

(i) Availability to visit the principal during his or her illness; and

(ii) Availability to fully participate in the decision-making process.

(4) When identifying the person best qualified to serve as the surrogate for the principal, the supervising healthcare provider may proceed in order of descending preference for service as a surrogate to:

(A) The principal's spouse, unless legally separated;

(B) The principal's adult child;

(C) The principal's parent;

(D) The principal's adult sibling;

(E) Any other adult relative of the principal; or

(F) Any other adult person who satisfies the requirements of subdivision (c)(2) of this section.

(5) If none of the individuals eligible to act as a surrogate under this subsection are reasonably available and informed consent would typically be sought from the principal, the supervising healthcare provider may make healthcare decisions for the principal after the supervising healthcare provider:

(A) Consults with and obtains the recommendations of an institution's ethics officers or ethics committee; or

(B) Obtains concurrence from a second physician who is:

(i) Not directly involved in the principal's health care;

(ii) Does not serve in a capacity of decision making, influence, or responsibility over the designated physician; and

(iii) Does not serve in a capacity under the authority of the designated physician's decision making, influence, or responsibility.

(6)(A) In the event of a challenge to the identification of the surrogate or the authority of the surrogate to act, it is a rebuttable presumption that the selection of the surrogate was valid.

(B) A person who challenges the selection of the surrogate has the burden of proving the invalidity of that selection by a preponderance of the evidence.

(d)(1) Except as provided in subdivision (d)(2) of this section:

(A) Neither the treating healthcare provider nor an employee of the treating healthcare provider, nor an operator of a healthcare institution, nor an employee of an operator of a healthcare institution may be designated as a surrogate; and

(B) A healthcare provider or employee of a healthcare provider may not act as a surrogate if the healthcare provider becomes the principal's treating healthcare provider.

(2) An employee of the treating healthcare provider or an employee of an operator of a healthcare institution may be designated as a surrogate if:

(A) The employee so designated is a relative of the principal by blood, marriage, or adoption; and

(B) The other requirements of this section are satisfied.

(e) A healthcare provider may require an individual claiming the right to act as surrogate for a principal to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed authority.

History. Acts 2013, No. 1264, § 1; 2017, No. 974, § 1.

Amendments. The 2017 amendment inserted "married minor" in (a)(1); substituted "a licensed" for "the designated" in (b)(1); substituted "identify" for "designate" in the introductory language of (c)(1); rewrote (c)(3); substituted "When identifying the person best qualified to

serve as the surrogate for the principal, the supervising healthcare provider may proceed" for "Consideration may be given" in (c)(4); added (c)(4)(F); rewrote the introductory language of (c)(5); inserted "or ethics committee" in (c)(5)(A); and substituted "identification" for "designation" in (c)(6)(A).

20-6-106. Authority of surrogate.

(a)(1) A surrogate shall make a healthcare decision in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the surrogate.

(2)(A) Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the principal's best interest.

(B) In determining the principal's best interest, the surrogate shall consider the principal's personal values to the extent known to the surrogate or agent.

(b) A surrogate who has not been designated by the principal may make all healthcare decisions for the principal that the principal could

make on the principal's own behalf, except that artificial nutrition and hydration may be withheld or withdrawn for a principal upon a decision of the surrogate only if:

(1) The action is authorized by the a living will or other written advance directive; or

(2) The supervising healthcare provider and a second independent physician certify in the principal's current clinical records that:

(A) The provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying; and

(B) The principal is highly unlikely to regain capacity to make medical decisions.

(c) A healthcare decision made by a surrogate or agent for a principal is effective without judicial approval.

History. Acts 2013, No. 1264, § 1; 2017, No. 974, § 1.

Amendments. The 2017 amendment added "or agent" in (a)(2)(B); redesignated part of the former introductory language of (b) as (b)(2); added (b)(1); substituted

"The supervising healthcare provider" for "the designated physician" in (b)(2); redesignated former (b)(1) and (b)(2) as (b)(2)(A) and (b)(2)(B); and inserted "or agent" in (c).

20-6-107. Requirement of guardian to comply with principal's individual instruction.

(a) Absent a court order to the contrary, a guardian shall comply with the principal's individual instructions and shall not revoke the principal's advance directive.

(b) Except as provided in § 28-65-102, a healthcare decision made by a guardian for the principal is effective without judicial approval.

History. Acts 2013, No. 1264, § 1; 2017, No. 974, § 1.

Amendments. The 2017 amendment

inserted "of guardian" in the section heading; and added "Except as provided in § 28-65-102" in (b).

20-6-108. Determination of capacity.

If a licensed physician makes a determination or is informed of a determination that a principal lacks or has recovered capacity or that another condition exists that affects an individual instruction or the authority of an agent, guardian, or surrogate, the licensed physician shall:

(1) Record promptly the determination in the principal's current clinical record; and

(2) Communicate the determination to the principal, if possible, and to any person authorized to make healthcare decisions for the principal.

History. Acts 2013, No. 1264, § 1; 2017, No. 974, § 1.

Amendments. The 2017 amendment

substituted "licensed" for "designated" twice in the introductory language.

20-6-109. Compliance by healthcare provider or institution.

(a) Except as provided in subsections (b)-(d) of this section, a healthcare provider or institution providing care to a principal shall comply with:

(1) An individual instruction of the principal and with a reasonable interpretation of that instruction by a person authorized to make healthcare decisions for the principal; and

(2) A healthcare decision for the principal made by a person authorized to make healthcare decisions for the principal to the same extent as if the decision had been made by the principal while having capacity.

(b) A healthcare provider may decline to comply with an individual instruction or healthcare decision for reasons of conscience.

(c) A healthcare institution may decline to comply with an individual instruction or healthcare decision if the instruction or decision:

(1) Is contrary to a policy of the institution that is based on reasons of conscience; and

(2) The policy was timely communicated to the principal or to a person authorized to make healthcare decisions for the principal.

(d) A healthcare provider or institution may decline to comply with an individual instruction or healthcare decision that requires medically inappropriate health care or health care contrary to generally accepted healthcare standards applicable to the healthcare provider or institution.

(e) A healthcare provider or institution that declines to comply with an individual instruction or healthcare decision under subsection (b), subsection (c), or subsection (d) of this section shall:

(1) Inform promptly the principal, if possible, or a person authorized to make healthcare decisions for the principal;

(2) Provide continuing care to the principal until a transfer can be effected or until a determination has been made that a transfer cannot be effected; and

(3)(A) Unless the principal or person authorized to make healthcare decisions for the principal refuses assistance, immediately make all reasonable efforts to assist in the transfer of the principal to another healthcare provider or healthcare institution that is willing to comply with the instruction or decision.

(B) If a transfer cannot be effected, the healthcare provider or institution shall not be compelled to comply.

History. Acts 2013, No. 1264, § 1.

20-6-110. Disclosure of medical or other healthcare information.

Unless otherwise specified in an advance directive, a person authorized to make healthcare decisions for a principal has the same rights as the principal to request, receive, examine, copy, and consent to the disclosure of medical or any other healthcare information.

History. Acts 2013, No. 1264, § 1.

20-6-111. Liability.

(a) A healthcare provider or healthcare institution acting in good faith and in accordance with generally accepted healthcare standards applicable to the healthcare provider or healthcare institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for:

(1) Complying with a healthcare decision of a person apparently having authority to make a healthcare decision for a principal, including a decision to withhold or withdraw health care;

(2) Declining to comply with a healthcare decision of a person based on a reasonable belief that the person then lacked authority; or

(3) Complying with an advance directive that, to the knowledge of the healthcare provider or healthcare institution, was valid when made and has not been revoked or terminated.

(b) An individual acting as agent or surrogate under this subchapter is not subject to civil or criminal liability or to discipline for unprofessional conduct for healthcare decisions made in good faith.

(c) A person who designates a surrogate under this subchapter is not subject to civil or criminal liability or to discipline for unprofessional conduct for a designation made in good faith.

History. Acts 2013, No. 1264, § 1.

20-6-112. Presumption of capacity.

(a) This subchapter does not affect the right of an individual to make healthcare decisions while having capacity to do so.

(b) An individual is presumed to have capacity to make a healthcare decision, to give or revoke an advance directive, and to designate or disqualify a surrogate.

History. Acts 2013, No. 1264, § 1.

20-6-113. Copies have same effect as originals.

A copy of a written advance directive, revocation of an advance directive, or designation or disqualification of a surrogate has the same effect as the original.

History. Acts 2013, No. 1264, § 1.

20-6-114. Presumptions not created — Death that results from withholding or withdrawal of health care does not constitute suicide, euthanasia, homicide, mercy killing, or assisted suicide.

(a) This subchapter does not create a presumption concerning the intention of an individual who has not made or who has revoked an advance directive.

(b) Notwithstanding any term of an insurance policy or annuity to the contrary, a death resulting from the withholding or withdrawal of health care in accordance with this subchapter does not constitute a suicide or homicide or legally impair or invalidate an insurance policy or an annuity providing a death benefit.

(c) The withholding or withdrawal of medical care from a principal in accordance with this subchapter does not constitute a suicide, euthanasia, homicide, mercy killing, or assisted suicide.

History. Acts 2013, No. 1264, § 1.

20-6-115. Court jurisdiction.

(a) A court of competent jurisdiction may enjoin or direct a health-care decision or order other equitable relief on a petition of:

- (1) A principal;
- (2) A principal's agent, guardian, or surrogate;
- (3) A healthcare provider or healthcare institution involved with the principal's care; or
- (4) An individual described in § 20-6-106(b).

(b) A proceeding under this section shall be expedited on the court's civil dockets.

History. Acts 2013, No. 1264, § 1.

20-6-116. Effect and interpretation of living wills.

(a) If a living will entered into before October 1, 2013, was valid at the time of execution, it remains valid.

(b) A living will entered into on or after October 1, 2013, that evidences an intent that it is entered into under this subchapter is valid.

(c) A living will entered into on or after October 1, 2013, that does not evidence an intent that it is entered into under this subchapter may be given effect as an individual instruction if it complies with this subchapter.

History. Acts 2013, No. 1264, § 1.

20-6-117. Effect and interpretation of durable powers of attorney.

- (a) If a durable power of attorney for health care entered into before October 1, 2013, was valid at the time of execution, it remains valid.
- (b) A durable power of attorney for health care entered into on or after October 1, 2013, that evidences an intent that it is entered into under this subchapter is valid.
- (c) A durable power of attorney for health care entered into on or after October 1, 2013, that does not evidence an intent that it is entered into under this subchapter may be given effect as an advance directive under this subchapter if it complies with this subchapter.

History. Acts 2013, No. 1264, § 1.

20-6-118. [Repealed.]

Publisher’s Notes. This section, concerning the repeal of conflicting laws, was repealed by Acts 2017, No. 974, § 2. The section was derived from Acts 2013, No. 1264, § 1.

SUBCHAPTER 2 — PATIENT RIGHT-TO-KNOW ACT

SECTION.	SECTION.
20-6-201. Title.	20-6-205. Affirmative defense in medical injury cases.
20-6-202. Legislative findings and purpose.	20-6-206. Injunctive relief.
20-6-203. Definitions.	20-6-207. Applicability — Construction.
20-6-204. Prohibited conduct.	

Effective Dates. Acts 2017, No. 754, § 2: Mar. 30, 2017. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that healthcare providers are often unable to obtain information about their patients when the healthcare providers terminate relationships with certain entities and relocate their practices; that patients are often unable to locate their healthcare providers due to efforts by certain entities to hinder access; that the Patient Right-to-Know Act will prohibit this activity and require certain entities to inform patients of the new practice location and new contact information of their healthcare providers; and that this act is immediately necessary to ensure continuity of care and prevent disruption of healthcare provider-patient relationships. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

20-6-201. Title.

This subchapter shall be known and may be cited as the “Patient Right-to-Know Act”.

History. Acts 2017, No. 754, § 1.

20-6-202. Legislative findings and purpose.

(a) The General Assembly finds that:

(1) Patients are entitled to continuity of care with their healthcare providers;

(2) Healthcare providers are prohibited legally and ethically from abandoning a patient before treatment has been concluded;

(3) When a healthcare provider changes practice locations, steps are necessary to ensure that the patient's continuity of care and the legal and ethical obligations of the healthcare provider are fulfilled; and

(4) Patients should be informed about any change in the practice location of their treating healthcare provider and should not be prevented from receiving this type of information.

(b) The purpose of this subchapter is to remove and prevent impediments to patients' maintaining continuity of care and keeping their treatment relationship with their chosen healthcare provider.

History. Acts 2017, No. 754, § 1.

20-6-203. Definitions.

As used in this subchapter:

(1)(A) "Entity" means any person, organization, or business entity of any type that engages a healthcare provider as an employee, independent contractor, member, or in any other capacity for the practice of medicine as defined in § 17-95-202.

(B) "Entity" does not include insurance companies, health maintenance organizations, or hospital and medical service corporations;

(2)(A) "Existing patient" means a person who is seen for a medical diagnosis or treatment, or both, by a healthcare provider within the previous twelve (12) months as evidenced by an entry in the medical record of the patient.

(B) The twelve-month period described in subdivision (2)(A) of this section shall be calculated by counting back twelve (12) months from the later of the following dates:

(i) The date that the healthcare provider's relationship with the entity terminates; or

(ii) The date that the healthcare provider gave the entity notice of a new practice location; and

(3) "Healthcare provider" means a person who:

(A) Is licensed by:

(i) The Arkansas State Medical Board;

(ii) The Arkansas State Board of Dental Examiners;

(iii) The Arkansas State Board of Nursing;

(iv) The Arkansas State Board of Chiropractic Examiners;

(v) The Arkansas Board of Podiatric Medicine; or

(vi) The State Board of Optometry; and

(B) Has ultimate responsibility and legal liability for the care of the patient.

History. Acts 2017, No. 754, § 1.

20-6-204. Prohibited conduct.

(a) If the healthcare provider has made new practice location information or new contact information available to the entity, an entity or person on behalf of an entity shall not:

(1) Mislead any patient about the new practice location of a healthcare provider or new contact information of a healthcare provider; or

(2) Fail to provide a patient with the new practice location of a healthcare provider or new contact information of a healthcare provider when requested.

(b)(1) When requested by a healthcare provider who is relocating his or her practice, an entity with a relationship with the healthcare provider shall within twenty-one (21) calendar days:

(A) Provide the healthcare provider with a list of the healthcare provider's existing patient names and addresses;

(B) Send a notice with the new practice location information to all of the healthcare provider's existing patients after providing the healthcare provider a copy of the proposed notice for review and comment; or

(C)(i) Post the new practice location information of the healthcare provider on the website of the entity after providing the healthcare provider a copy of the proposed posting for review and comment.

(ii) The posting shall remain on the website of the entity for twelve (12) months after the healthcare provider's last day of employment with the entity posting the information.

(2) Within two (2) business days of the request described in subdivision (b)(1) of this section, the entity shall provide the healthcare provider with a list or schedule of upcoming patient appointments with the healthcare provider and the contact information of the patients.

History. Acts 2017, No. 754, § 1.

20-6-205. Affirmative defense in medical injury cases.

If patient abandonment or other medical injury occurs due to a violation by an entity of this subchapter, the violation shall be an affirmative defense for the physician in a claim brought by the injured patient who shall be entitled to bring a claim against the entity.

History. Acts 2017, No. 754, § 1.

20-6-206. Injunctive relief.

(a) An affected patient or healthcare provider may file an action seeking an injunction of a violation of this subchapter in the circuit court of:

- (1) Pulaski County;
- (2) The county in which the healthcare provider has his or her practice located;
- (3) The county in which the affected patient resides; or
- (4) The county in which the entity is located.

(b) Upon the filing of a complaint, the court may issue a temporary injunction on the violation without notice or bond.

(c) If the plaintiff patient or healthcare provider establishes that this subchapter has been violated, the court may enter an order permanently enjoining the violation of this subchapter or otherwise enforcing compliance with this subchapter.

(d) A prevailing plaintiff shall be entitled to:

- (1) The greater of liquidated damages in the amount of one thousand dollars (\$1,000) per day per violation, or actual damages; and
- (2) Reasonable attorney's fees and costs.

(e) A violation of this subchapter shall constitute an unfair and deceptive act or practice as defined under the Deceptive Trade Practices Act, § 4-88-101 et seq.

History. Acts 2017, No. 754, § 1.

20-6-207. Applicability — Construction.

(a) This subchapter:

(1) Applies to any express or implied contract, agreement, or understanding entered into, renewed, modified, or extended on or after March 30, 2017; and

(2) Does not amend or repeal any portion of the Medical Corporation Act, § 4-29-301 et seq., or the Dental Corporation Act, § 4-29-401 et seq.

(b) Any purported waiver of the benefits or requirements of this subchapter is void and against the public policy of this state.

History. Acts 2017, No. 754, § 1.

SUBCHAPTER 3 — ARKANSAS PHYSICIAN ORDER FOR LIFE-SUSTAINING TREATMENT ACT

SECTION.

- 20-6-301. Title.
 20-6-302. Legislative findings.
 20-6-303. Definitions.
 20-6-304. Physician order for life-sustaining treatment form.
 20-6-305. Compliance.
 20-6-306. Review and revision.

SECTION.

- 20-6-307. Relationship with advance directives.
 20-6-308. Liability.
 20-6-309. Voluntary signing.
 20-6-310. Criminal penalty.
 20-6-311. Applicability — Death — Life insurance.

SECTION.
20-6-312. Copy of physician order for life-

sustaining
form.

treatment

A.C.R.C. Notes. Acts 2017, No. 504,
§ 2, provided: “The State Board of Health
shall adopt the following form and may by

rule revise the form so long as the revisions are consistent with the intent of this act.”

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

First follow these orders, then contact Physician.
A copy of the executed POLST form is a legally binding, valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

Patient Last Name:

Patient First Name:

Patient Middle Name:

Date form Prepared:

Patient Date of Birth:

A

Check One

CARDIOPULMONARY RESUSCITATION (CPR):
NOTE ... If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.
☐ Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)
☐ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B

Check One

MEDICAL INTERVENTIONS:
If patient is found with a pulse and/or is breathing.
☐ Full Treatment – primary goal of prolonging life by all medically effective means.
In addition to treatment described in Selective Treatment and Comfort Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ Trial Period of Full Treatment.
☐ Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.
In addition to treatment described in Comfort Treatment, use medical treatment and IVs as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
☐ Request transfer to hospital only if comfort needs cannot be met in current location.
☐ Comfort Treatment – primary goal of maximizing comfort.
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location.

C

ADDITIONAL ORDERS:

D

INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legal Representative
☐ Advance Directive dated _____, available and reviewed
☐ Advance Directive not available.
☐ No Advance Directive.

Signature of Physician My signature below indicates to the best of my knowledge these orders are consistent with the patient's intentions and medical condition.
Print Physician Name: Physician Phone Number: Physician License #:
Physician Signature: (required) Date:

Signature of Patient or Legal Representative I am aware my consent to this form is voluntary. By signing this form, a legal representative acknowledges this request regarding resuscitative measures is consistent with the known wishes of, and with the best interest of, the individual who is the subject of the form.
Print Name: Relationship: (write self if patient)
Signature: (required) Date:
Mailing Address: Phone:

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

20-6-301. Title.

This subchapter shall be known and may be cited as the “Arkansas Physician Order for Life-Sustaining Treatment Act”.

History. Acts 2017, No. 504, § 1.

20-6-302. Legislative findings.

The General Assembly finds that:

(1) It is important for individuals to make healthcare decisions before a medical crisis or emergency occurs;

(2) Healthcare planning is a process, rather than a single decision, that helps individuals think about the type of care that they would want if they become seriously ill or incapacitated, and encourages individuals to talk with their loved ones and physicians regarding their healthcare decisions;

(3) An advance directive gives individuals the ability to put their wishes in writing and to identify another individual who would speak for them if they become unable to speak or make decisions for themselves;

(4) The physician order for life-sustaining treatment form complements an advance directive, if existing, by taking an individual's intentions regarding life-sustaining treatment, such as the intentions set forth in an advance directive, and converting the individual's intentions into a medical order;

(5) The hallmarks of a physician order for life-sustaining treatment form are that a physician order for life-sustaining treatment form:

(A) Is:

(i) Signed;

(ii) Immediately actionable as medical orders on a standardized form;

(iii) A conspicuous, clearly identifiable form; and

(iv) Recognized, adopted, and honored across treatment settings; and

(B) Addresses a range of life-sustaining treatment interventions as well as the patient's preferred intensity of treatment for each intervention; and

(6) The physician order for life-sustaining treatment form is used only for patients with a serious illness or medical frailty when a physician would not be surprised if the patient died within one (1) year.

History. Acts 2017, No. 504, § 1.

20-6-303. Definitions.

As used in this subchapter:

(1)(A) "Healthcare facility" means an institution, building, agency, or a portion of an institution, building, or agency that is used, operated, or designed to provide healthcare services, medical treatment, nursing care, rehabilitative care, or preventative care to an individual, regardless of whether the institution, building, or agency is a private organization, a public organization, a nonprofit organization, or a for-profit organization.

(B) "Healthcare facility" includes without limitation:

- (i) An ambulatory surgical facility;
- (ii) A home health agency;
- (iii) A hospice;
- (iv) A hospital;
- (v) An infirmary;
- (vi) A long-term care facility;
- (vii) An assisted living facility;
- (viii) A mental health center;
- (ix) An outpatient facility;
- (x) A rehabilitation facility; and
- (xi) A residential treatment facility;

(2) “Healthcare provider” means an individual who is licensed, certified, or otherwise authorized or permitted by the laws of this state to administer health care in the ordinary course of business or in the practice of a profession, including without limitation:

(A) An emergency medical care provider; and

(B) An individual providing home and community-based services;

(3) “Legal representative” means the same as a person authorized to consent on the principal’s behalf under § 20-6-102;

(4) “Patient” means an individual who has a critical medical condition or a terminal illness and for whom a physician has determined that a physician order for life-sustaining treatment is consistent with the individual’s goals of care;

(5) “Physician” means an individual who is licensed to practice medicine or osteopathic medicine in this state; and

(6) “Physician order for life-sustaining treatment” means a document containing orders by a physician regarding life-sustaining treatment and medical interventions in accordance with the wishes of a patient, or if the wishes of the patient are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the best interest of the patient.

History. Acts 2017, No. 504, § 1.

20-6-304. Physician order for life-sustaining treatment form.

(a) The State Board of Health shall prescribe a standardized physician order for life-sustaining treatment form that:

(1) Is signed and dated by:

(A) The patient or the legal representative of the patient; and

(B) The physician of the patient;

(2) Includes:

(A) The name and date of birth of the patient; and

(B) The intentions of the patient regarding care, including without limitation the administration of cardiopulmonary resuscitation and the level of medical interventions in the event of a medical emergency; and

(3) Is easily distinguishable to facilitate recognition by healthcare providers and healthcare facilities.

(b) A legal representative may sign a physician order for life-sustaining treatment form on behalf of a patient who lacks capacity to do so, guided by:

(1) The express or implied intentions of the patient; or

(2) If the intentions of the patient are unknown and cannot be reasonably determined, the best interest of the patient given the overall medical condition and prognosis of the patient.

(c)(1) The physician order for life-sustaining treatment form shall be completed by a physician based upon patient intentions and medical indications.

(2) During the process of completing the physician order for life-sustaining treatment form, the physician may:

(A) Explain:

(i) The physician order for life-sustaining treatment form; and

(ii) The medical interventions and procedures offered by the life-sustaining treatment form; and

(B) Inform the patient or the legal representative of the patient about the difference between an advance directive and the physician order for life-sustaining treatment form.

(d) This subchapter does not authorize a physician to unilaterally create a physician order for life-sustaining treatment on behalf of an individual.

History. Acts 2017, No. 504, § 1.

20-6-305. Compliance.

(a) Except as provided in subsection (c) of this section, a healthcare provider and a healthcare facility shall treat a patient in accordance with the physician order for life-sustaining treatment form.

(b) A physician order for life-sustaining treatment form is valid in a healthcare facility, regardless of whether the physician who signed the life-sustaining treatment form has clinical privileges at the healthcare facility.

(c)(1) A healthcare provider or healthcare facility is not required to comply with a physician order for life-sustaining treatment form if the physician order for life-sustaining treatment form requires medically ineffective health care or health care contrary to generally accepted healthcare standards applicable to a healthcare provider or healthcare facility.

(2) A healthcare provider or healthcare facility may decline to comply with an executed physician order for life-sustaining treatment form based upon religious beliefs or moral convictions if the healthcare provider or healthcare facility:

(A) Promptly informs the patient or legal representative of the patient regarding the inability to carry out the physician order for life-sustaining treatment form;

(B) Provides continuing care to the patient until a transfer can be made or a determination has been made that the transfer cannot be made; and

(C)(i) Makes all reasonable efforts to assist in the prompt transfer of the patient to another healthcare provider or healthcare facility that is willing to comply with the executed physician order for life-sustaining treatment form.

(ii) If a transfer cannot be made, the healthcare provider or healthcare facility shall not be compelled to comply with the physician order for life-sustaining treatment form.

(3) This section does not authorize a healthcare provider or healthcare facility to withhold life-sustaining treatment against the wishes of a patient or a legal representative.

History. Acts 2017, No. 504, § 1.

20-6-306. Review and revision.

(a)(1) An executed physician order for life-sustaining treatment form may be reviewed periodically by the physician of the patient.

(2) The physician may:

(A) Conduct an evaluation of the patient; and

(B) In consultation with the patient or the legal representative of the patient, issue a new physician order for life-sustaining treatment form consistent with the most current information available about the health status and goals of care of the patient.

(b)(1) The new physician order for life-sustaining treatment form shall be:

(A) Recorded on a new physician order for life-sustaining treatment form; and

(B) Signed in compliance with § 20-6-304.

(2) Once a new physician order for life-sustaining treatment form has been executed, the previous physician order for life-sustaining treatment form shall be nullified.

(c) A patient with the capacity to make his or her own healthcare decisions may, at any time, request alternative treatment to the treatment that was ordered on the physician order for life-sustaining treatment form.

(d) The legal representative of the patient who does not have the capacity to make his or her own healthcare decisions shall consult with the physician who is the treating physician of the patient before making a request to modify the orders reflected in the physician order for life-sustaining treatment form of the patient.

History. Acts 2017, No. 504, § 1.

20-6-307. Relationship with advance directives.

(a)(1) A physician order for life-sustaining treatment form is not intended to replace an advance directive.

(2) In executing a physician order for life-sustaining treatment form, a patient, the legal representative of the patient when applicable, and the physician shall make a good-faith effort to locate and incorporate treatment preferences documented in a previously executed advance directive, when appropriate and desired by the patient.

(b) In the event of a conflict with a physician order for life-sustaining treatment form and an advance directive, either:

(1) The document executed most recently by the patient shall take precedence regarding the medical decision or treatment preference at issue; or

(2) If both the advance directive and the physician order for life-sustaining treatment form were executed by the legal representative of the patient, the advance directive shall take precedence regarding the medical decision or treatment preference at issue.

(c) This section does not prohibit or require the execution, revocation, or modification of an advance directive.

History. Acts 2017, No. 504, § 1.

20-6-308. Liability.

A healthcare provider, healthcare facility, or employee or agent of the healthcare provider or healthcare facility is not subject to civil or criminal liability or discipline for unprofessional conduct for:

(1) Complying with a physician order for life-sustaining treatment form based upon a good-faith assumption that the physician order for life-sustaining treatment form was valid when executed and that the physician order for life-sustaining treatment form was not revoked or terminated;

(2) Failing to comply with a physician order for life-sustaining treatment form based upon a good faith determination that:

(A) The physician order for life-sustaining treatment form was not valid; or

(B) The physician order for life-sustaining treatment form requires medically ineffective health care or health care contrary to generally accepted healthcare standards applicable to the healthcare provider or healthcare facility; or

(3) Declining to comply with an executed physician order for life-sustaining treatment form based upon religious beliefs or moral convictions if the healthcare provider or healthcare facility complies with the requirements of § 20-6-305.

History. Acts 2017, No. 504, § 1.

20-6-309. Voluntary signing.

(a) The signing of a physician order for life-sustaining treatment form by a patient or legal representative of the patient is voluntary.

(b)(1) A person or entity, including without limitation a healthcare provider, healthcare facility, employer, or health insurance carrier, shall not require an individual to execute a physician order for life-sustaining treatment form as a condition of being insured for, or receiving, healthcare services.

(2) If a healthcare provider or healthcare facility complies with subdivision (b)(1) of this section, the healthcare provider or healthcare facility may have a policy to offer a physician order for life-sustaining treatment form to appropriate individuals as part of a conversation about:

- (A) Goals of care;
- (B) Personal values and preferences;
- (C) Benefits of various treatment options; and
- (D) Avoidance of unwanted burden.

(c) This subchapter does not:

(1) Create a presumption concerning the intention of an individual who has not executed a physician order for life-sustaining treatment form with respect to the use, withholding, or withdrawal of life-sustaining procedures in the event of a terminal condition; or

(2) Affect the right of an individual to make decisions regarding the use of life-sustaining procedures as long as the individual has the capacity to make a decision.

History. Acts 2017, No. 504, § 1.

20-6-310. Criminal penalty.

(a) It is unlawful for a person to knowingly:

(1) Conceal, cancel, deface, obliterate, or damage a physician order for life-sustaining treatment form without the consent of the patient or the legal representative of the patient;

(2)(A) Cause an individual to execute a physician order for life-sustaining treatment form by undue influence, fraud, or duress.

(B) As used in this section, “undue influence” includes without limitation:

(i) Charging a different rate or fee for insurance coverage or healthcare services based upon whether the individual consents to a physician order for life-sustaining treatment form or has executed a physician order for life-sustaining treatment form;

(ii) Requiring a healthcare provider to have an internal policy to offer a physician order for life-sustaining treatment form to any individual;

(iii) Providing any financial incentive, payment, discount, or rating incentive for having an internal policy or procedure relating to the completion of a physician order for life-sustaining treatment form as applied to a healthcare provider or healthcare facility; or

(iv) Imposing a rating or reimbursement penalty if a healthcare provider or healthcare facility fails to achieve a target for physician order for life-sustaining treatment form completions; or

(3) Falsify or forge a physician order for life-sustaining treatment form of another person that results in a direct change of health care provided to the patient.

(b) A person who violates this section is guilty of a Class D felony.

(c) This section does not prevent payment to a healthcare provider or healthcare facility for consultation with or counseling of a patient concerning a physician order for life-sustaining treatment form or for offering advance directive healthcare planning.

History. Acts 2017, No. 504, § 1.

20-6-311. Applicability — Death — Life insurance.

(a) A death that results from compliance with a physician order for life-sustaining treatment form does not constitute a suicide, homicide, or abuse, for any reason.

(b)(1) The execution of a physician order for life-sustaining treatment form does not affect the sale, procurement, or issuance of a life insurance policy or annuity policy.

(2) A life insurance policy or annuity policy shall not be impaired or invalidated if emergency care or life-sustaining treatment is withheld from an insured individual who has executed a physician order for life-sustaining treatment form.

(c) This subchapter does not:

(1) Condone, authorize, or approve mercy killing, euthanasia, or physician-assisted suicide; or

(2) Permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

History. Acts 2017, No. 504, § 1.

20-6-312. Copy of physician order for life-sustaining treatment form.

A copy of an executed physician order for life-sustaining treatment form has the same effect as the original physician order for life-sustaining treatment form.

History. Acts 2017, No. 504, § 1.

CHAPTER 7

STATE BOARD OF HEALTH — DEPARTMENT OF HEALTH

SUBCHAPTER.

1. GENERAL PROVISIONS.

SUBCHAPTER

- 2. ARKANSAS HEALTH DEPARTMENT BUILDING AND LOCAL GRANT ACT.
- 3. STATE HEALTH DATA CLEARINGHOUSE ACT.
- 4. DEPARTMENT OF HEALTH PUBLIC HEALTH LABORATORY ACT OF 2003.
- 5. ARKANSAS HEALTH-CONSCIOUS SHOPPER ACT.
- 6. PRESCRIPTION DRUG MONITORING PROGRAM ACT.
- 7. COMBATING PRESCRIPTION DRUG ABUSE ACT.

Publisher's Notes. The State Board of Health and its functions, powers, and duties were transferred by a type 4 transfer to the Department of Health by Acts 1971, No. 38, § 11. Pursuant to § 25-2-107, governing type 4 transfers, the Governor is required to approve rules and regulations issued by the board and the board's nominee for director.

Cross References. Division of indus-

trial hygiene, § 11-5-201 et seq.

Enforcement of narcotic drug law, § 20-64-219.

Food, Drug, and Cosmetic Act, enforcement, § 20-56-222.

Health Services Permit Agency, § 20-8-101 et seq.

State health agencies, generally, § 20-8-101 et seq.

RESEARCH REFERENCES

Am. Jur. 39 Am. Jur. 2d, Health, § 8 et seq.

C.J.S. 39A C.J.S., Health & E, § 9 et seq.

SUBCHAPTER 1 — GENERAL PROVISIONS

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A.C.R.C. Notes. Acts 2005, No. 1954, § 4, provided: “State Board of Health.

“(a) Effective at 12:01 AM on July 1, 2005, the State Board of Health is transferred to the Department of Health and Human Services.

“(b) For the purposes of this act, the State Board of Health shall receive administrative support from the Division of Health of the Department of Health and Human Services but shall retain exactly the same powers, authorities, duties, and functions prescribed by law as it had prior to the transfer and shall have all rule- and regulation-making authority prescribed by law to the Department of Health before the transfer, except as provided for in this act, including, but not limited to:

“(1) Rule making, regulation, licensing, and registration;

“(2) The promulgation of rules, rates, regulations, and standards;

“(3) Examinations, investigations, inspections, and reviews; and

“(4) The rendering of findings, orders, and adjudications.”

Acts 2007, No. 384, § 1, provided: “Creation of the Department of Health.

“(a) There is created the Department of Health, that is to be established if the Governor orders the separation of the Division of Health of the Department of Health and Human Services from the Department of Health and Human Services.

“(b) If the Governor establishes the Department of Health under subsection (a) of this section, the Arkansas Code Revision Commission shall replace all references in the Arkansas Code to the:

“(1) ‘Division of Health of the Department of Health and Human Services’ or ‘Division of Health’ with ‘Department of Health’; and

“(2) ‘Department of Health and Human Services’ with ‘Department of Human Services’.

“(c) Sections 2 through 12 of this act become effective only if the Governor establishes the Department of Health under subsection (a) of this section.”

Acts 2007, No. 384, § 2, provided:

“Transfer of the Division of Health of the Department of Health and Human Services out of the Department of Health and Human Services.

“(a) Effective sixty (60) days after the Governor establishes the Department of Health under this act, and as provided in the orders of the Governor, the following may be transferred to the Department of Health:

“(1) Authority, powers, duties, and functions as established by law for the Division of Health of the Department of Health and Human Services, including purchasing, budgeting, fiscal, accounting, human resources, payroll, legal, information systems, maintenance, program support, administrative support, and other management functions;

“(2) Records, personnel, property, unexpended balances of appropriations, allocations, or other funds of the Division of Health of the Department of Health and Human Services;

“(3) Rulemaking, regulation, and licensing, promulgation of rules, rates, regulations, and standards, and the rendering of findings, orders, and adjudications as established by law for the Division of Health of the Department of Health and Human Services, except as otherwise specified in this act.

“(b) Powers, duties, and functions, including without limitation, rulemaking, regulation, and licensing, promulgation of rules, rates, regulations, and standards, budgetary responsibilities, and the rendering of findings, orders, and adjudications as established by law for the Breast Cancer Control Program or other trans-

ferred entities within the Division of Health of the Department of Health and Human Services shall be retained as they existed on June 30, 2005.

“(c) The Governor may appoint a Surgeon General in accordance with § 20-7-103.”

Acts 2007, No. 384, § 3, provided:

“Transfer of the State Board of Health to the Department of Health.

“(a) Effective sixty (60) days after the Department of Health is established, the State Board of Health shall be transferred to the Department of Health.

“(b) The State Board of Health shall receive administrative support from the Department of Health and shall retain the same powers, authorities, duties, and functions prescribed by law as it had before the transfer and shall have all rule-making authority prescribed by law to the Division of Health of the Department of Health and Human Services before the transfer, except as provided for in this act, including, without limitation:

“(1) Rule making, licensing, and registration;

“(2) The promulgation of rules, rates, and standards;

“(3) Examining, investigating, inspecting, and reviewing; and

“(4) The rendering of findings, orders, and adjudications.”

Publisher's Notes. Because of the enactment of Subchapter 2 of this chapter by Acts 1989, No. 749, § 1, the existing provisions of this chapter have been designated as Subchapter 1.

Acts 1993, No. 350, § 7, provided: “(a) All powers, functions and duties heretofore vested in and exercised by the Health Building Commission are hereby transferred to and shall hereafter be vested in the State Board of Health.

“(b) All funds appropriated to and all property, both real and personal, vested in the Health Building Commission are hereby transferred and shall be made available to the State Board of Health.

“(c) The Health Building Commission is hereby abolished.”

Effective Dates. Acts 1881, No. 85, § 14: effective on passage.

Acts 1895, No. 152, § 5: effective on passage.

Acts 1913, No. 96, § 33: Feb. 25, 1913. Emergency declared.

Acts 1923, No. 92, § 6: Feb. 9, 1923. Emergency clause provided: “This act being necessary for the public peace, health and safety, an emergency is hereby declared and this act shall be in full force and effect from and after its passage and approval by the governor.”

Acts 1929, No. 109, § 3: Mar. 9, 1929. Emergency clause provided: “In view of the fact that the need for the protection of the public health is imperative and the changes herein contemplated are necessary for a more efficient administration of the State Board of Health, the immediate operation of this act is necessary for the preservation of the public peace, health and safety, and this act shall take effect and be in force and effect from and after its passage.”

Acts 1931, No. 235, § 12: Mar. 27, 1931. Emergency clause provided: “This act being necessary for the health and safety of the State shall take effect and be in full force from and after its passage and approval.”

Acts 1949, No. 302, § 5: Mar. 19, 1949. Emergency clause provided: “It appearing to the Legislature that the membership of the State Board of Health as presently constituted does not adequately give representation to those other professions interested and informed in matters of public health, and it appearing that there be an immediate public need for such representation, an emergency is hereby declared to exist, and this act being necessary for the immediate preservation of the public peace, health and safety, shall take effect and be in full force from and after its passage and approval.”

Acts 1953, No. 282, § 3: Mar. 11, 1953. Emergency clause provided: “It is hereby determined by the General Assembly that the law authorizing the employment of an assistant State Health Officer has been inadvertently repealed and that it is essential to the continued operation of the State Health Department that an assistant State Health Officer be authorized, and the passage of this act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval.”

Acts 1959, No. 186, § 5: Mar. 6, 1959. Emergency clause provided: “It appearing to the Legislature that the membership of the State Board of Health as presently

constituted does not adequately give representation to those other professions interested and informed in matters of public health, and it appearing that there be an immediate public need for such representation, an emergency is hereby declared to exist, and this act being necessary for the immediate preservation of the public peace, health and safety, shall take effect and be in full force from and after its passage and approval."

Acts 1961, No. 433, § 4: Mar. 15, 1961. Emergency clause provided: "It appearing to the Legislature that the membership of the State Board of Health as presently constituted does not adequately give representation to those other professions interested and informed in matters of public health, and it appearing that there be an immediate public need for such representation, an emergency is hereby declared to exist, and this Act being necessary for the immediate preservation of the public peace, health and safety, shall take effect and be in full force from and after its passage and approval."

Acts 1965, No. 469, § 27: Mar. 20, 1965. Emergency clause provided: "It is hereby found and declared by the General Assembly that the present building is wholly inadequate to house the State Board of Health, the State Health Officer, the State Department of Health and the divisions, units, agencies, officers and employees thereof, with the result that it is impossible to properly and efficiently carry out functions and duties required by law; that because of such inadequacy the State is not having its health and related needs properly taken care of, all of which is to the detriment of the public health, safety and welfare; and that only by the immediate operation of this Act can these conditions be alleviated. Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety, shall take effect and be in full force from and after its passage and approval."

Acts 1971, No. 204, § 3: Mar. 2, 1971. Emergency clause provided: "The General Assembly having found that one of the major functions of the Board of Health of the State of Arkansas is the inspection of meat and meat products and that the prevention and control of disease in animals is a necessary part of the process of assuring a supply of wholesome meat

products and that the presence of a licensed veterinarian on the State Board of Health will contribute greatly to the efficiency and performance of the duties of said Board and that there is an immediate need for the appointment of such licensed veterinarian to the said State Board of Health. An emergency is hereby declared and this Act being necessary for the immediate protection of the public health, safety and welfare shall be in full force and effect immediately upon its passage and approval."

Acts 1975, No. 383, § 4: Mar. 12, 1975. Emergency clause provided: "It is hereby declared by the General Assembly that only an immediate operation of this Act can correct inequities and rectify problems created for State Health Board Members engaged in functions and duties required by law and alleviate all troublesome conditions associated therewith. Therefore, an emergency is hereby declared to exist and this Act being necessary to the public peace, health and safety shall take effect upon its passage and approval."

Acts 1977, No. 318, § 3: Mar. 1, 1977. Emergency clause provided: "It is hereby found and determined by the General Assembly that many of the functions and responsibilities of the Board of Health of the State of Arkansas vitally affect the operation and administration of hospital facilities in this State and that the membership on the State Board of Health of a hospital administrator would enhance the State Board of Health's efficiency and ability to deal with issues affecting hospitals while at the same time insuring that the interests of the hospitals are represented, and that there is an immediate need for the appointment of a hospital administrator to the Board of Health. Therefore, an emergency is hereby declared and this Act being necessary for the immediate protection of the public health, safety and welfare shall be in full force and effect immediately upon its passage and approval."

Acts 1977, No. 889, § 39: July 1, 1977. Emergency clause provided: "It is hereby found and determined by the Seventy-First General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness of this Act on July 1, 1977 is essential to

the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1, 1977 could work irreparable harm upon the proper administration and providing of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health, and safety shall be in full force and effect from and after July 1, 1977."

Acts 1979, No. 198, § 3: Feb. 21, 1979. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that there is an immediate need to establish the most efficient possible administrative structure in the Department of Health. Therefore, an emergency is hereby declared to exist and this Act, being necessary for the immediate preservation of the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Acts 1979, No. 797, § 3: Apr. 10, 1979. Emergency clause provided: "It is hereby found and determined by the General Assembly that the present law prescribing qualifications of the Assistant Director of the Department of Health is unduly restrictive in that it requires such person to be a licensed physician; that this Act is designed to revise such qualifications to require only that the Assistant Director be knowledgeable in the field of public health and should be given effect immediately. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1987, No. 146, § 4: Mar. 10, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that due to current revenue shortfalls the services offered by the Department of Health to the citizens of this State are threatened; that an equitable method of maintaining these services is to provide for a fee to be paid by those citizens who request the assistance of the State Department of Health; that this Act is designed to provide for the collection of such fees and should be given effect immedi-

ately. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1987, No. 399, § 4: Mar. 25, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that due to current revenue shortfalls the services offered by the Department of Health to the citizens of this State are threatened; that an equitable method of maintaining these services is to provide for additional fees to be paid by those citizens who request the assistance of the State Department of Health; that this Act is designed to provide for the collection of additional fees and should be given effect immediately. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1993, No. 350, § 11: Mar. 3, 1993. Emergency clause provided: "It is hereby found and determined by the General Assembly that the Arkansas Department of Health is critically in need of additional space and that, accordingly, the authorization to construct or acquire space enabled by this act, must be obtained as soon as feasible. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1993, No. 485, § 5: Mar. 12, 1993. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that the provisions of this Act are immediately necessary due to regulations and requirements of the federal government concerning laboratories which impact public health programs at the Arkansas Department of Health; and that this legislation will permit mid-level professionals to serve patients in public health clinics which will improve the efficiency of clinic operations thereby increasing services to patients. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health, and safety,

shall be in full force and effect from and after its passage and approval."

Acts 1995, No. 270, § 19: July 1, 1995. Emergency clause provided: "It is hereby found and determined by the Eightieth General Assembly, that various laws have been enacted since the passage of the Revenue Classification Law which have changed or created various revenues collected by the State, and that this amendment to the Revenue Classification Law is necessary in order to reflect the various taxes, licenses, fees and other revenues levied and collected for the support of and use by State Government as they currently exist and from which appropriations which become effective July 1, 1995 have been made by the Eightieth General Assembly. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 1995."

Acts 1995 (1st Ex. Sess.), No. 13, § 13: Oct. 23, 1995. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that the current system of funding the state judicial system has created inequity in the level of judicial services available to the citizens of the state; and it is further determined that the current method of financing the state judicial system has become so complex as to make the administration of the system impossible, and the lack of reliable data on the current costs of the state judicial system prohibits any comprehensive change in the funding of the system at this time. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Acts 1997, No. 179, § 38: Feb. 17, 1997. Emergency clause provided: "It is hereby found and determined by the General Assembly that Act 10 of the First Extraordinary Session of 1995 abolished the Joint Interim Committee on Public Health, Welfare, and Labor and in its place established the House Interim Committee and Senate Interim Committee on Public Health, Welfare, and Labor; that various sections of the Arkansas Code refer to the Joint Interim Committee on Public Health, Welfare, and Labor and should be

corrected to refer to the House and Senate Interim Committees on Public Health, Welfare, and Labor; that this act so provides; and that this act should go into effect immediately in order to make the laws compatible as soon as possible. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 1997, No. 250, § 258: Feb. 24, 1997. Emergency clause provided: "It is hereby found and determined by the General Assembly that Act 1211 of 1995 established the procedure for all state boards and commissions to follow regarding reimbursement of expenses and stipends for board members; that this act amends various sections of the Arkansas Code which are in conflict with the Act 1211 of 1995; and that until this cleanup act becomes effective conflicting laws will exist. Therefore an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 1997, No. 396, § 6: Mar. 7, 1997. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the current law refers to a certificate of need process from agencies that have been abolished; that this act is necessary to remove the inconsistencies in the law and to provide for a permit of approval; and that this act is immediately necessary for the administration of the law. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and

safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 2003, No. 1723, § 15: Apr. 22, 2003. Emergency clause provided: "It is found and determined by the Eighty-fourth General Assembly that there is a pressing and immediate need for the construction of a modern public health laboratory; that this act will provide adequate funding for the construction of the laboratory; and that this act must become effective immediately. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

Acts 2007, No. 384, § 11: Mar. 19, 2007. Emergency clause provided: "It is found

and determined by the General Assembly of the State of Arkansas that many services delivered by the various divisions, offices, and units the Department of Health and Human Services are essential to the public health, safety, and welfare; that the state fiscal year begins July 1; that beginning the process of decoupling the Division of Health of the Department of Health and Human Services from the Department of Health and Human Services during a fiscal year will cause disruptions of services and unnecessary time, effort, and expense in reallocating appropriations, budgets, personnel, equipment, and capital expenditures during a fiscal year; and that this act is immediately necessary because a delay beyond the beginning of the fiscal year will disrupt essential programs and services. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

20-7-101. Violations — Penalties.

(a)(1) Every firm, person, or corporation violating any of the provisions of this act or any of the orders, rules, or regulations made and promulgated in pursuance hereof shall be deemed guilty of a misdemeanor and upon conviction thereof shall be punished by a fine of not less than one hundred dollars (\$100) nor more than five hundred dollars (\$500) or by imprisonment not exceeding one (1) month, or both.

(2) Each day of violation shall constitute a separate offense.

(b)(1)(A)(i) Every firm, person, or corporation who violates any of the rules or regulations issued or promulgated by the State Board of Health or who violates any condition of a license, permit, certificate, or any other type of registration issued by the board may be assessed a civil penalty by the board. The penalty shall not exceed one thousand dollars (\$1,000) for each violation.

(ii) Each day of a continuing violation may be deemed a separate violation for purposes of penalty assessments.

(B) However, no civil penalty may be assessed until the person charged with the violation has been given the opportunity for a hearing on the violation.

(2) All fines collected under this subsection shall be deposited into the State Treasury and credited to the Public Health Fund to be used to defray the costs of administering this section.

(3) Subject to such rules and regulations as may be implemented by the Chief Fiscal Officer of the State, the disbursing officer for the Department of Health may transfer all unexpended funds relative to fines collected under this subsection, as certified by the Chief Fiscal Officer of the State, to be carried forward and made available for expenditures for the same purpose for any following fiscal year.

(4) All rules and regulations promulgated pursuant to this subsection shall be reviewed by the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor or appropriate subcommittees thereof.

History. Acts 1913, No. 96, § 28; C. & M. Dig., § 5146; Pope's Dig., § 6417; A.S.A. 1947, § 82-121; Acts 1987, No. 146, § 2; 1991, No. 990, §§ 1, 5; 1997, No. 179, § 19.

Publisher's Notes. Acts 1913, No. 96, § 28, as amended, is also codified as § 14-262-101.

Meaning of "this act". Acts 1913, No. 96, codified as §§ 14-262-101 — 14-262-105, 20-7-101 — 20-7-106, 20-7-109, 20-7-110, 20-7-114, 20-7-118, 20-7-122, 20-7-125.

CASE NOTES

Cited: Davis v. Rodman, 147 Ark. 385, 227 S.W. 612 (1921).

20-7-102. Members — Appointment.

(a) The State Board of Health shall consist of the following members, to be appointed by the Governor subject to confirmation by the Senate as follows:

(1)(A) Seven (7) members of the board shall be licensed medical doctors of good professional standing, to be appointed by the Governor as follows:

(i) One (1) member shall be appointed from each of the four (4) congressional districts of this state as established by § 7-2-101 et seq.; and

(ii) Three (3) members shall be appointed from the state at large by the Governor after consulting the Arkansas Medical Society, Inc.

(B) Notwithstanding the provisions of subdivision (a)(1)(A) of this section, at least one (1) of the positions allocated for licensed medical doctors shall be an osteopathic physician appointed by the Governor after consulting the Arkansas Osteopathic Medical Association from the state at large;

(2) One (1) member shall be a regularly licensed, registered, and practicing dentist who has at least seven (7) years' experience in the

practice of his or her profession in this state. This member shall be appointed by the Governor after consulting the Arkansas State Dental Association;

(3) One (1) member shall be a professional engineer as defined in § 17-30-101 who has at least seven (7) years' experience in the practice of his or her profession in this state. This member shall be appointed by the Governor after consulting The Arkansas Society of Professional Engineers;

(4) One (1) member shall be a regularly licensed professional nurse who has been a resident of the state for at least seven (7) years preceding the appointment and who has at least a bachelor's degree and five (5) years' nursing experience in the state. This member shall be appointed from a list by the Governor after consulting the Arkansas Nurses Association;

(5) One (1) member shall be a regularly licensed pharmacist who has been actively engaged in the practice of pharmacy for at least seven (7) years preceding his or her appointment. This member shall be appointed by the Governor after consulting the Arkansas Pharmacist's Association;

(6) One (1) member shall be a regularly licensed veterinarian who has been actively engaged in the practice of veterinary medicine for at least seven (7) years preceding his or her appointment. This member shall be appointed by the Governor after consulting the Arkansas Veterinary Medical Association;

(7) One (1) member shall be a registered sanitarian who has at least seven (7) years' experience in the practice of his or her profession preceding his or her appointment. This member shall be appointed by the Governor after consulting the Arkansas State Board of Sanitarians;

(8) One (1) member shall be a hospital administrator who has at least seven (7) years' experience in the practice of his or her profession in Arkansas. This member shall be appointed by the Governor after consulting the Arkansas Hospital Association, Inc.;

(9) One (1) member shall be a regularly licensed, registered, and practicing optometrist who has at least seven (7) years' experience in the practice of his or her profession in this state. This member shall be appointed by the Governor after consulting the Arkansas Optometric Association, Inc.;

(10) One (1) member shall be a regularly licensed and practicing chiropractor. This member shall be appointed by the Governor after consulting the Arkansas Chiropractic Physicians Association;

(11) One (1) member shall be a restaurant operator who has owned or operated a restaurant for a minimum of five (5) years. This member shall be appointed by the Governor after consulting the Arkansas Hospitality Association, Inc.;

(12) One (1) member shall be a consumer representative who has an interest in public health. This member shall be appointed by the Governor from the state at large;

(13) One (1) member shall be more than sixty (60) years of age and represent the elderly. This person shall not be actively engaged in or

retired from any occupation, profession, or industry to be regulated by the board. The member shall be appointed by the Governor from the state at large and be subject to confirmation by the Senate;

(14) One (1) member shall be a licensed doctor of podiatric medicine of good professional standing who has at least seven (7) years' experience in the practice of the profession in this state. The member shall be appointed by the Governor after consulting the Arkansas Podiatric Medical Association;

(15) One (1) member shall be a member of the Arkansas Public Health Association. The member shall be appointed by the Governor after consulting the Arkansas Public Health Association, Inc.;

(16) One (1) member shall be a licensed medical doctor of good professional standing who shall be appointed by the Governor from a rural county that contains a medically underserved population in the state; and

(17) One (1) member shall be the Director of the Department of Health.

(b) Each of the members of the board so appointed shall take the oath prescribed by the Arkansas Constitution for state officers and shall be commissioned by the Governor in the same manner as other state officials.

History. Acts 1913, No. 96, §§ 1, 2; C. & M. Dig., §§ 5125, 5126; Acts 1929, No. 109, § 1; Pope's Dig., §§ 6388, 6389; Acts 1949, No. 302, §§ 1, 2; 1959, No. 186, §§ 1, 2; 1961, No. 433, § 1; 1963, No. 240, § 1; 1971, No. 204, § 1; 1975, No. 295, § 1; 1977, No. 318, § 1; 1979, No. 198, § 1; 1981, No. 713, § 1; 1983, No. 131, §§ 1-3, 5; 1983, No. 135, §§ 1-3, 5; A.S.A. 1947, §§ 6-623 — 6-626, 82-101, 82-103; Acts 1987, No. 112, § 1; 1991, No. 829, § 1; 1995, No. 747, § 1; 2003, No. 1450,

§ 1; 2005, No. 1954, § 5; 2007, No. 384, § 4; 2011, No. 897, § 15; 2015, No. 1100, § 46.

Amendments. The 2015 amendment inserted "subject to confirmation by the Senate" in the introductory language of (a); substituted "by the Governor after consulting" for "from a list of not fewer than three (3) names presented by" and similar language throughout (a); rewrote (a)(10); and inserted "by the Governor" in (a)(16).

CASE NOTES

Constitutionality.

This act, creating a State Board of Health, was not invalid as creating a permanent office in violation of the Constitution. *Ft. Smith Dist. v. Eberle*, 125 Ark. 350, 188 S.W. 821 (1916).

Cited: *Ark. Medical Soc'y v. Ark. Medical Soc'y*, 287 Ark. 9, 695 S.W.2d 827 (1985).

20-7-103. Members — Officers.

(a) The members of the State Board of Health shall elect one (1) of the members as president.

(b)(1) The State Board of Health shall nominate to the Governor a Director of the Department of Health.

(2) The Governor shall appoint the director who shall serve at the pleasure of the Governor.

(3) The director shall:

(A) Serve as the State Health Officer;

(B) Serve as the Secretary for the State Board of Health and shall have all the powers of a member of the State Board of Health;

(C)(i)(a) Be a licensed medical doctor who is a graduate of a school of medicine recognized by the Arkansas State Medical Board;

(b) Hold a graduate degree in public health or a graduate degree in a recognized public health discipline from an accredited college or university or have equivalent knowledge and experience in public health as determined by the State Board of Health; and

(c) Have experience in the practice of public health and in leadership and management, the sufficiency of which shall be determined by the State Board of Health; or

(ii) Hold a doctoral degree in public health or a doctoral degree in a recognized public health discipline from an accredited college or university with at least five (5) years of experience in the practice of public health and at least ten (10) years of experience in the leadership and management of a large complex organization, the sufficiency of which shall be determined by the State Board of Health.

History. Acts 1913, No. 96, § 2; C. & M. Dig., § 5126; Acts 1929, No. 109, § 1; Pope's Dig., § 6389; Acts 1949, No. 302, § 2; 1959, No. 186, § 2; 1979, No. 198, § 1; A.S.A. 1947, § 82-103; Acts 2005, No. 1954, § 5; 2007, No. 384, § 4; 2013, No. 435, § 1.

Amendments. The 2013 amendment deleted the former last sentence in (a) and added (b).

20-7-104. Members — Compensation.

All appointed members of the State Board of Health may receive expense reimbursement and stipends in accordance with § 25-16-901 et seq.

History. Acts 1913, No. 96, § 27; C. & M. Dig., § 5142; Pope's Dig., § 6413; Acts 1955, No. 82, § 1; 1975, No. 383, § 1; A.S.A. 1947, § 82-105; Acts 1997, No. 250, § 178; 2005, No. 1954, § 5.

20-7-105. Proceedings.

(a)(1) The State Board of Health shall meet at least one (1) time every three (3) months.

(2) Upon the call of the President of the State Board of Health or a majority of the members of the board, the board shall meet at such other times as may be necessary in the interest of public health.

(b)(1) The board may adopt bylaws regulating the transaction of its business and provide within the bylaws for the appointment of committees to which the board may delegate authority and power for all duties committed to the board, but under the direction and subject to the control of the board.

(2) The board may also adopt and use an official seal.

(c) A majority of the members of the board shall constitute a quorum for the transaction of business and for the performance of such duties as the board may prescribe.

History. Acts 1913, No. 96, §§ 3, 4; C. & M. Dig., §§ 5127, 5128; Acts 1929, No. 109, § 2; Pope's Dig., §§ 6390, 6399; A.S.A. 1947, §§ 82-107, 82-108; Acts 2005, No. 1954, § 5; 2007, No. 384, § 5.

20-7-106. Office.

The office of the State Board of Health shall be located in Little Rock, and the board shall be furnished with all necessary equipment and supplies, including laboratory supplies, books, stationery, blanks, furniture, etc., as are provided other officers of the state and as are necessary for carrying on the work of the board, and the office is to be provided in a suitable building to be designated by the Director of the Department of Health.

History. Acts 1913, No. 96, § 24; C. & M. Dig., § 5139; Pope's Dig., § 6410; A.S.A. 1947, § 82-102; Acts 2005, No. 1954, § 5; 2007, No. 384, § 6.

20-7-107. Appointment of assistant director.

The Director of the Department of Health may appoint and employ an assistant director who shall be knowledgeable in the field of public health and whose duty it shall be to assist the director in the general supervision of the affairs of his or her office and in the enforcement of quarantine and sanitation throughout the state.

History. Acts 1953, No. 282, § 1; 1979, No. 797, § 1; A.S.A. 1947, § 82-104.

20-7-108. Engagement of certain personnel.

From time to time, the State Board of Health may engage suitable persons to render sanitary service, to make or supervise practical and scientific investigations and examinations requiring expert skill, and to prepare plans and to report relative to sanitary service.

History. Acts 1881, No. 85, § 10, p. 177; C. & M. Dig., § 5132; Pope's Dig., § 6403; A.S.A. 1947, § 82-114.

20-7-109. Authority to regulate public health — Exceptions.

(a)(1) Power is conferred on the State Board of Health to make all necessary and reasonable rules and regulations of a general nature for:

- (A) The protection of the public health and safety;
- (B) The general amelioration of the sanitary and hygienic conditions within the state;
- (C) The suppression and prevention of infectious, contagious, and communicable diseases;

(D) The proper enforcement of quarantine, isolation, and control of such diseases; and

(E) The proper control of chemical exposures that may result in adverse health effects to the public.

(2) All rules and regulations promulgated pursuant to this subsection shall be reviewed by the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor or appropriate subcommittees thereof.

(b) However, if a patient can be treated with reasonable safety to the public health, he or she shall not be removed from his or her home without his or her consent, or the consent of the parents or guardian in the case of a minor, and the rules and regulations, when made, shall be printed in pamphlet form, with such numbers of copies as may be necessary for the distribution of the information to health bodies, health and sanitary officers, and the public generally.

(c) The board shall not regulate the practice of medicine or healing nor interfere with the right of any citizen to employ the practitioner of his or her choice.

History. Acts 1913, No. 96, § 6; C. & M. Dig., § 5130; Pope's Dig., § 6401; A.S.A. 1947, § 82-110; Acts 1991, No. 990, §§ 3, 5; 1997, No. 179, § 20.

Cross References. Adoption of rules and regulations for abortion clinics by Department of Health, § 20-9-302.

CASE NOTES

ANALYSIS

Constitutionality.

Effect of Other Laws.

Constitutionality.

Regulations of the State Board of Health requiring vaccination of school children against smallpox were a valid exercise of the police power of the state and did not violate the religious freedom guaranteed by U.S. Const., Amend. 1, even though the regulation contravened religious beliefs. *Wright v. DeWitt Sch. Dist.*, 238 Ark. 906, 385 S.W.2d 644 (1965);

Mannis v. State, 240 Ark. 42, 398 S.W.2d 206, cert. denied, 384 U.S. 972, 86 S. Ct. 1864, 16 L. Ed. 2d 683 (1966).

Effect of Other Laws.

Acts 1931, No. 169, did not repeal the authority of the State Board of Health to make regulations requiring the vaccination of school children. *Seubold v. Ft. Smith Special School Dist.*, 218 Ark. 560, 237 S.W.2d 884 (1951).

Cited: *Ark. Beverage Co. v. Heath*, 257 Ark. 991, 521 S.W.2d 835 (1975); *Land v. Ark. Dep't of Health*, 282 Ark. 191, 667 S.W.2d 651 (1984).

20-7-110. Study and prevention of diseases.

(a)(1) The State Board of Health has general supervision and control of all matters pertaining to the health of the citizens of this state.

(2) The board shall make a study of the causes and prevention of infectious, contagious, and communicable diseases, and, except as otherwise provided in this act, the board shall have direction and control of all matters of quarantine regulations and enforcement. The board shall have full power and authority to prevent the entrance of such diseases from points outside the state.

(3) The board shall also have direction and control over all sanitary and quarantine measures for dealing with all infectious, contagious, and communicable diseases within the state and direction and control to suppress them and prevent their spread.

(b) Whenever the health of the citizens of this state is threatened by the prevalence of any epidemic or contagious disease in this or any adjoining state and, in the judgment of the Governor, the public safety demands action on the part of the board, then the Governor shall call the attention of the board to the facts and order it to take such action as the public safety of the citizens demands to prevent the spread of the epidemic or contagious disease.

History. Acts 1895, No. 152, § 1, p. 236; 1913, No. 96, § 5; C. & M. Dig., §§ 5129, 5135; Pope's Dig., §§ 6400, 6406; A.S.A. 1947, §§ 82-109, 82-115.

Meaning of "this act". See note to § 20-7-101.

RESEARCH REFERENCES

Ark. L. Rev. Constitutional Law — Fluoridation of City Water, 10 Ark. L. Rev. 496.

CASE NOTES

ANALYSIS

Constitutionality.
Vaccination.

Constitutionality.

This section does not constitute a delegation of legislative authority. *State v. Martin*, 134 Ark. 420, 204 S.W. 622 (1918).

Regulations of the State Board of Health requiring vaccination of school children against smallpox is a valid exercise of the police power of the state and does not violate the religious freedom guaranteed by U.S. Const., Amend. 1,

even though the regulation contravened religious beliefs. *Wright v. DeWitt Sch. Dist.*, 238 Ark. 906, 385 S.W.2d 644 (1965); *Mannis v. State*, 240 Ark. 42, 398 S.W.2d 206, cert. denied, 384 U.S. 972, 86 S. Ct. 1864, 16 L. Ed. 2d 683 (1966).

Vaccination.

The State Board of Health has implied power to prescribe the method of vaccination against smallpox. *Allen v. Ingalls*, 182 Ark. 991, 33 S.W.2d 1099 (1930).

Cited: *Land v. Ark. Dep't of Health*, 282 Ark. 191, 667 S.W.2d 651 (1984).

20-7-111. Administration of certain federal acts.

(a) The State of Arkansas does accept the benefits of any acts now passed or hereafter to be passed by the United States Congress to provide for cooperation with the states in the protection of mothers and infants and promotion of a public health program.

(b)(1) The State Board of Health is designated as the board for the purpose of carrying into effect the provisions of the federal acts and this section and shall have all necessary authority to cooperate with the federal authorities administering the acts of the United States Congress.

(2) The board shall administer any legislation pursuant thereto enacted by the State of Arkansas under this section for promotion of a health program.

(c)(1) The Director of the Department of Health shall act as executive officer of the board for the purpose of administering the federal acts and this section.

(2) The director shall carry into effect such rules and regulations as the federal authorities and the board may adopt pursuant to the federal acts and this section.

(d) The Treasurer of State is designated and appointed custodian of all moneys received by the state from the appropriation made by the United States Congress, and he or she may receive and provide for the proper custody of the moneys and make disbursements in the manner provided by law and for the purpose specified in this section.

(e) The allocation of funds under this section shall be made to the respective counties in consecutive order as they make application and qualify for the funds.

(f)(1) Any person, firm, or corporation violating any of the provisions of this section upon conviction shall be guilty of a violation and shall be fined not more than five hundred dollars (\$500) at the discretion of the court.

(2) Each day that the violation is committed shall constitute a separate offense.

History. Acts 1931, No. 235, §§ 3-6, 10, A.S.A. 1947, §§ 82-123 — 82-128; Acts 11; Pope's Dig., §§ 6392-6395, 6397, 6398; 2005, No. 1994, § 103.

CASE NOTES

Cited: Jones v. Wyeth Labs., Inc., 457 F. Supp. 35 (W.D. Ark. 1978).

20-7-112. Inspections.

(a) It is made the duty of all officers and agents who have the control, charge, or custody of any public structure, work, grounds, or erection, or of any plan, description, outlines, drawings, or charts thereof or relating thereto, made, kept, or controlled under any public authority, to permit and facilitate the examination and inspection and the making of copies of these items by any officer or person authorized by the State Board of Health.

(b) The members of the board and such other officers or persons as may at any time be authorized by the board, without fee or hindrance, to enter, examine, and survey all grounds, erections, vehicles, structures, apartments, buildings, and plans when the public health may be promoted or in any way preserved.

History. Acts 1881, No. 85, § 10, p. 177; C. & M. Dig., § 5132; Pope's Dig., § 6403; A.S.A. 1947, § 82-114.

20-7-113. Nuisances.

(a)(1) At any time, the Governor may require the State Board of Health to examine nuisances or questions affecting the security of life and health in any locality in the state, and in such cases the State Board of Health shall have all the necessary powers to make those examinations. The State Board of Health shall report the results to the Governor within the limits of time which he or she shall prescribe for the examination and report to be prepared and submitted.

(2) At any time, whether an investigation is at the request of the State Board of Health, or whenever the Governor shall have directed an examination and report to be made by the State Board of Health into any alleged nuisance, any board of health of any city of the state may appoint and select any one (1) of its officers as its representative during the examination of any nuisance. This representative officer shall have a seat at and be entitled to take part in all the deliberations of the State Board of Health during the investigation but without the right to vote.

(b) When approved by the Governor, the report of the examination shall be filed in the office of the Secretary of State, and the Governor, in relation to the matters or things found and certified by the State Board of Health to be a nuisance, may declare them to be public nuisances and order them to be changed as he or she shall direct, or be abated and removed.

(c) Any violation of an order shall be held and punished as a misdemeanor, and thereafter the Governor, by his or her order in writing which is certified under his or her official seal and directed to the officers of the county in which the nuisance shall be situated, may require the prosecuting attorney, the sheriff, and the other officers of every county to take all necessary measures to execute the order of the Governor and to have it obeyed.

History. Acts 1881, No. 85, §§ 8, 9, p. Dig., §§ 6404, 6405; A.S.A. 1947, §§ 82-177; C. & M. Dig., §§ 5133, 5134; Pope's 112, 82-113.

20-7-114. Public health laboratory.

(a)(1) The State Board of Health shall establish, equip, and maintain a public health laboratory that shall be used for making:

(A) Analyses of foods and drugs to enforce pure food and drug laws;

(B) Analyses of the environment to investigate cases or suspected cases of human exposure; and

(C) Investigations of cases and suspected cases of malaria, diphtheria, typhoid fever, tuberculosis, epidemic cerebro-spinal meningitis, glanders, hookworm disease, rabies, and other infectious, contagious, communicable, and debilitating diseases.

(2) The public health laboratory shall be established and maintained at the Department of Health under the direct supervision of the Director of the Department of Health or his or her authorized representatives.

(b)(1) The department may establish fees to be charged for performing analyses of various types of samples submitted to the public health laboratory for examination.

(2) All fees levied and collected under this subsection are special revenues and shall be deposited into the State Treasury, there to be credited to the Public Health Fund.

(c) Subject to rules and regulations as may be implemented by the Chief Fiscal Officer of the State, the disbursing officer for the department may transfer all unexpended funds relative to the laboratory services that pertain to fees collected, as certified by the Chief Fiscal Officer of the State, to be carried forward and made available for expenditures for the same purpose for any following fiscal year.

History. Acts 1913, No. 96, § 21; C. & M. Dig., § 5136; Pope's Dig., § 6407; A.S.A. 1947, § 82-118; Acts 1987, No. 146, § 1; 1991, No. 990, §§ 4, 5; 1993, No. 485, § 1; 1997, No. 179, § 21; 2013, No. 564, § 2.

Amendments. The 2013 amendment

substituted "Department of Health" for "Division of Health of the Department of Health and Human Services" twice in (a)(2); deleted the (b)(1)(A) designation and deleted (b)(1)(B); substituted "department" for "division" in (b)(1) and (c); and deleted former (b)(3) and (d).

20-7-115. Transportation of dead bodies.

(a)(1) The State Board of Health shall prepare the necessary methods and forms and prescribe the rules regulating the issue and use of transfer permits, with the proper coupons attached thereto, to be issued by local organized boards of health or health officers, for the transportation of the dead bodies of persons which are to be transported for burial beyond the limits of the counties where the death occurred.

(2) In all cases, the State Board of Health shall require the coupons to be attached to the permits, to be detached and preserved by every common carrier or the person in charge of any vessel, railroad train, or vehicle to whom the dead bodies shall be delivered for transportation.

(b) Any violation of these rules and regulations shall be a misdemeanor.

History. Acts 1881, No. 85, § 7, p. 177; C. & M. Dig., § 5131; Pope's Dig., § 6402; A.S.A. 1947, § 82-111.

20-7-116. [Repealed.]

Publisher's Notes. This section, concerning perinatal health, was repealed by Acts 2009, No. 952, § 1. The section was

derived from Acts 1979, No. 159, §§ 1-5; 1979, No. 723, § 3; A.S.A. 1947, §§ 5-911.1 — 5-911.5.

20-7-117. Hospices — Definition — State Hospice Office — Creation.

(a) There is created within the Department of Health a State Hospice Office to be administered in a division of the department to be designated by the Director of the Department of Health.

(b)(1) The office shall:

(A) Coordinate the care of terminally ill persons with all existing agencies, programs, and facilities;

(B) Implement rules, regulations, and standards for hospice care in general agreement with guidelines of the National Hospice and Palliative Care Organization and the Hospice and Palliative Care Association of Arkansas, Inc. and in compliance with the Centers for Medicare & Medicaid Services;

(C) Provide technical assistance and information to developing hospices;

(D) Maintain a central storehouse of information and reference materials relating to the hospice concept and disseminate this to programs and individuals on request in an equitable manner and accept and respond to inquiries relating to hospice; and

(E) Assist the Arkansas State Hospice Association in developing the hospice concept in this state and networking hospice programs with existing medical communities and human service facilities.

(2) All functions and duties of the office shall be carried out in accordance with the laws of Arkansas and the regulations of the Health Services Permit Agency, the Health Services Permit Commission, and the Centers for Medicare & Medicaid Services.

(c)(1) The regulations and requirements of the Health Services Permit Agency and the Health Services Permit Commission shall be revised to include separate permit-of-approval categories of healthcare facilities entitled "hospice facilities" and "hospice agencies" and to develop criteria for granting the permits of approval for hospice facilities and for hospice agencies for which applications shall be filed in accordance with the criteria.

(2) A hospice facility or hospice agency shall not convert its licensure to any other license.

(d) As used in this section, "hospice" or "hospice program" means an autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill patient and the patient's family, and which employs an interdisciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement. The care shall be available twenty-four (24) hours a day, seven (7) days a week, and provided on the basis of need, regardless of ability to pay.

(e) The licensure fee for a hospice shall be an annual fee of five hundred dollars (\$500).

History. Acts 1983, No. 283, §§ 1-4; A.S.A. 1947, §§ 5-911.6 — 5-911.9; Acts 1997, No. 396, §§ 1, 2; 1997, No. 574, § 3; 2001, No. 1800, §§ 4, 5; 2007, No. 827, § 146.

Cross References. Rights of the terminally ill, § 20-17-201 et seq.

Health Facility Services Revolving Fund, § 19-5-1089.

20-7-118. Annual conference for health officers.

(a) There shall be an annual conference of county health officers and city health officers of this state, meeting at such time and place as the State Board of Health designates. The President of the State Board of Health or some member of the board shall preside at the conference.

(b) Each of the several counties, towns, and cities may provide for and pay the necessary expenses of its county health officer or city health officer for attendance at the conference.

History. Acts 1913, No. 96, § 31; C. & M. Dig., § 5145; Pope's Dig., § 6416; A.S.A. 1947, § 82-120.

20-7-119. Identification tags and bracelets.

(a) When application is made and upon the payment of the fees provided in this section, the Department of Health may prepare and furnish to the applicant either a suitable metal tag commonly referred to as "dog tag" or an identification bracelet which may be inscribed with, in addition to the name and address of the person, the birth date, blood type, and any other pertinent medical information that might be needed in case of an accident or emergency with respect to the person.

(b) The department shall charge a fee of fifty cents (50¢) for each metal tag or dog tag and a fee of one dollar (\$1.00) for each identification bracelet containing the information authorized in this section.

(c) All fees collected under this section shall be deposited into the State Treasury as special revenues, and the Treasurer of State shall credit them, after deducting from them the collection charge authorized by law, to the Public Health Fund to be used to defray the cost of this section and for the maintenance and operation of the department.

History. Acts 1965, No. 433, §§ 1, 2; A.S.A. 1947, §§ 82-131, 82-132.

20-7-120. No right to enter home or take charge of children.

(a) No official, agent, or representative of the Department of Health shall have any right under this section to enter any home over the objection of the owner of the home or to take charge of any child over the objection of either or both parents or of the person standing in loco parentis or having custody of the child.

(b) Nothing in this section shall be construed as limiting the power of a parent or guardian or person standing in loco parentis to determine what treatment or correction shall be provided for a child or the agencies to be employed for these purposes.

History. Acts 1923, No. 92, § 5; Pope's Dig., § 6453; A.S.A. 1947, § 82-129.

20-7-121. Annual report.

(a) It shall be the duty of the State Board of Health to make an annual written report through the Director of the Department of Health to the Governor on or before January 1 of each year.

(b) The report shall include:

(1) A financial statement covering the expenditures of all funds appropriated for the board's purposes;

(2) So much of the proceedings of the board and information concerning vital and mortuary statistics, knowledge respecting diseases, and instructions on the subject of sanitation and hygiene which may be thought useful by the board for dissemination among the people; and

(3) Such suggestions as to legislative action as the board deems necessary.

History. Acts 1913, No. 96, § 29; C. & M. Dig., § 5143; Pope's Dig., § 6414; A.S.A. 1947, § 82-122.

20-7-122. Reports for general distribution.

The State Board of Health may publish for general distribution such reports and other matter as it may deem useful in promoting the interest of the public health of this state.

History. Acts 1913, No. 96, § 23; C. & M. Dig., § 5138; Pope's Dig., § 6409; A.S.A. 1947, § 82-119.

20-7-123. Fees.

(a) All revenue derived from fees collected pursuant to this section shall be deposited as special revenues into the State Treasury, where they shall be credited to the Public Health Fund.

(b) These fees are as follows:

(1) All fees prescribed in the Vital Statistics Act, § 20-18-101 et seq., which are as follows:

(A) A fee of fifteen dollars (\$15.00) collected by the State Registrar of Vital Records for the filing of a delayed certificate of birth;

(B) A fee of fifteen dollars (\$15.00) collected by the state registrar for the filing of a delayed certificate of death or marriage;

(C) A fee of fifteen dollars (\$15.00) collected by the state registrar for issuing a new certificate of birth for a person who has been legitimated, or whose paternity has been determined, or whose name has been changed;

(D)(i) A fee of one dollar (\$1.00) collected by the clerks of the county courts upon the application of any person for marriage.

(ii) This fee is in addition to any other fees;

(E)(i) Except as provided in subdivision (b)(1)(E)(ii) of this section, a fee of fifteen dollars (\$15.00) collected by the state registrar for the amendment of any record.

(ii) For a hospital that requests an amendment of a record, a fee of two dollars (\$2.00);

(F) A fee of five dollars (\$5.00) collected by the state registrar for the making and certification of any certificate or record other than a death certificate;

(G) A fee of:

(i) Four dollars (\$4.00) collected by the state registrar for the making and certification of a single copy of a death certificate; and

(ii) One dollar (\$1.00) collected for the making and certification of each additional copy of a death certificate;

(H)(i) A fee of:

(a) Five dollars (\$5.00) collected by the state registrar for an examination and search of the files for any birth, marriage, divorce, or putative father record;

(b) Four dollars (\$4.00) for an examination and search of the files for a death record.

(ii) The fees set out in this subdivision (b)(1)(H) shall be paid before searching the record; and

(I) A fee of five dollars (\$5.00) collected by the state registrar for establishing a new certificate of birth under § 20-18-406;

(2)(A) A fee to be collected for the review of plans and specifications covering improvements that by law or regulation are required to be reviewed by the State Board of Health or Department of Health, including without limitation plans and specifications covering waterworks, sewage works, swimming pools, hospitals and related facilities, food service and food processing establishments, and plumbing in public facilities.

(B) The fee imposed under subdivision (b)(2)(A) of this section shall be one percent (1%) of the estimated cost, with a maximum fee of five hundred dollars (\$500) and a minimum fee of fifty dollars (\$50.00), calculated and paid on the basis of the engineering estimate of the total cost of the particular improvement, which estimate is to be submitted with the plans and specifications for review.

(C) If the maximum fee of five hundred dollars (\$500) is paid, no engineering estimate of the total cost need be submitted with the plans and specifications; and

(3) A fee of fifty dollars (\$50.00) to be collected by the board or the department for each cemetery inspection as required by law or regulation.

History. Acts 1965, No. 469, § 10; 1983, No. 378, § 2; 1985, No. 351, §§ 1, 4; A.S.A. 1947, §§ 82-130, 82-130.1; Acts 1987, No. 399, §§ 1, 2; 1993, No. 350, § 6; 1993, No. 403, § 11; 1995, No. 270, § 14; 1995, No. 1254, § 29; 1995, No. 1256, § 20; 1995 (1st Ex. Sess.), No. 13, § 4; 2001, No. 957, §§ 1-4; 2003, No. 1723, § 14; 2007, No. 827, § 147; 2007, No. 1059, § 1.

A.C.R.C. Notes. The operation of subdivision (b)(1) may be affected by the enactment of Act 1256 of 1995, codified principally at § 16-10-301 et seq.

Pursuant to Acts 2007, No. 827, § 240, the amendment of § 20-7-123 by Acts 2007, No. 1059, § 1 supersedes the amendment of § 20-7-123 by Acts 2007, No. 827, § 147.

Publisher's Notes. Acts 1985, No. 351,

§ 5 provided that it was the purpose and intent of Acts 1985, No. 351 to levy increased or additional fees to be collected by the Division of Vital Records with part of the additional fees to be credited to the Public Health Fund. It was not the intent of that Act to in any way jeopardize revenues pledged to secure bonds issued under the provisions of Acts 1965, No. 469 or to otherwise impair the obligations on such bonds.

Acts 1985, No. 351, § 4, is also codified as § 20-18-306.

Cross References. Circuit court clerks fees, § 21-6-402 et seq.

Marriage license fee, § 14-20-111.

Amount of fees levied by this section going to the Health Department Technology Fund, § 19-6-485.

20-7-124. Disposition of certain fees.

All fees collected by the Department of Health for food-related establishment permits, septic tank permits, and milk permits shall be deposited into the State Treasury to the credit of the Public Health Fund and shall be for the use of the Division of Environmental Health Protection of the Department of Health.

History. Acts 1977, No. 889, § 36.

Cross References. Food services es-

tablishments, § 20-57-201 et seq.

Milk products, § 20-59-101 et seq.

20-7-125. Payment of certain salaries and expenses.

All salaries and other expenses provided for by this act which are not required to be paid by counties, cities, and incorporated towns shall be paid out of the Public Health Fund.

History. Acts 1913, No. 96, § 30; C. & M. Dig., § 5144; Pope's Dig., § 6415; A.S.A. 1947, § 82-106.

Meaning of "this act". See note to § 20-7-101.

20-7-126. Payment of overtime for home health employees.

(a) The Department of Health may make overtime payments to employees engaged in the performance of home health activities.

(b) The payments are to be in addition to compensation otherwise due the employees at the same rate currently paid to the employees for regular time, but on an hourly basis.

History. Acts 1989 (1st Ex. Sess.), No. 991, § 33.

A.C.R.C. Notes. Former § 20-7-126, concerning payment of overtime for home

health employees, is deemed to be superseded by this section. The former section was derived from Acts 1985, No. 718, § 25.

20-7-127. [Repealed.]

Publisher's Notes. This section, concerning fees for visits to local health units, was repealed by Acts 2017, No. 206, § 1.

The section was derived from Acts 1987, No. 677, §§ 1-3; 1993, No. 350, §§ 4, 5.

20-7-128. Maintenance fee for breath testing instruments.

(a)(1) The State Board of Health may assess a fee for the maintenance of breath testing instruments by law enforcement agencies for purposes contained in the Omnibus DWI or BWI Act, § 5-65-101 et seq., and § 5-65-201 et seq.

(2) The fees collected shall be used for the support of the maintenance program as appropriated by law.

(3) This subsection does not exclude manufacturer-approved repair services.

(b) The fee imposed shall not exceed the cost of maintenance by the Department of Health.

(c)(1) Funds derived from the fees levied under this section are special revenues and shall be collected by the department and deposited into the State Treasury, where they shall be credited to the Public Health Fund.

(2) Subject to such rules and regulations as may be implemented by the Chief Fiscal Officer of the State, the disbursing officers for the department may transfer all unexpended funds relative to the blood alcohol instrument maintenance program funds outlined in this section, as certified by the Chief Fiscal Officer of the State, to be carried forward and made available for the expenditures for the same purpose for any following year.

History. Acts 1989, No. 577, § 1.

20-7-129. Reimbursement for certain medical supplies or services.

(a)(1) The Department of Health may implement a reimbursement system to recover part or all of the costs of delivering services.

(2) For the purpose of vaccine and vaccine administration reimbursement, if a private healthcare insurer declines or does not respond to a request to contract with the department within ninety (90) days of the request to contract, the private healthcare insurer shall reimburse the department at the rate paid to an in-network provider.

(b) The system shall provide that fees shall be collected only from those patients who are financially able to pay the fee and that no one shall be denied services because of inability to pay.

(c)(1) Funds derived from the fees shall be used exclusively for the purchase of medical supplies or services necessary to enable the department to continue to provide essential health care.

(2) The department may transfer six hundred thousand dollars (\$600,000) in any fiscal year to the State Health Department Building and Local Grant Trust Fund for the purposes established by § 20-7-204.

(d)(1) Funds collected by the department under this section shall be deposited into the State Treasury. These funds shall be credited to the Public Health Fund to be used exclusively for support of medical supplies or services.

(2) Subject to rules and regulations as may be implemented by the Chief Fiscal Officer of the State, all unexpended funds that pertain to fees collected shall be carried forward and made available for expenditure for the same purposes for any following fiscal year.

History. Acts 1989, No. 387, §§ 1, 2; 2013, No. 564, § 1; 2015, No. 1052, § 1; 2017, No. 206, § 2.

Amendments. The 2013 amendment, in (a), substituted “Department of Health” for “State Board of Health may adopt rules and regulations to” and “delivering” for “certain medical supplies or”; substituted “Department of Health” for “Divi-

sion of Health of the Department of Health and Human Services” in (c); deleted former (d) and (e) and redesignated former (f) as present (d).

The 2015 amendment added designation (a)(1); and added (a)(2).

The 2017 amendment added the designation (c)(1); and added (c)(2).

20-7-130. Recovery of expenditures for extraordinary operations.

(a) The purpose of this section is to more equitably allocate the costs between the state and responsible parties when unforeseen circumstances arise as a result of accidents and other man-made causes which require assistance from the Department of Health. The authority to recover these expenses would enable the department to replace funds budgeted for routine activities which were spent for a department response to nonroutine, unplanned circumstances creating the potential for adverse health effects such as transportation accidents involving food and drugs, environmental contamination, and food product contamination.

(b)(1) The State Board of Health may promulgate rules and regulations necessary to carry out the intent and purpose of this section.

(2) In adopting these rules, the board shall define the circumstances under which recovery should be pursued and the method to determine the amount of each recovery, which shall be based on costs.

(c) The department may recover from the responsible party or parties actual costs incurred in participation during extraordinary, time-consuming operations such as damage assessment, sampling, monitoring, health studies, and product evaluations which arise from unforeseen circumstances.

(d) All moneys levied and collected under this section are special revenues and shall be deposited into the State Treasury, there to be credited to the Public Health Fund.

(e) Subject to rules and regulations as may be implemented by the Chief Fiscal Officer of the State, the disbursing officer for the department may transfer all unexpended funds relative to the recovery of expenditures program that pertain to moneys collected, as certified by the Chief Fiscal Officer of the State, to be carried forward and made available for expenditures for the same purpose for any following fiscal year.

History. Acts 1989, No. 384, §§ 1, 2.

20-7-131. Local control of county or city units of Department of Health.

(a) The mayor or county judge of any city or county that is providing facilities for a local unit of the Department of Health shall be consulted before the hiring of or the removal of the administrator of the local unit.

(b) Notwithstanding the Freedom of Information Act of 1967, § 25-19-101 et seq., the department with the consent of the employee may share personnel information with a mayor or county judge.

(c) Furthermore, any employee removed as administrator of a local unit shall be allowed to participate in the state grievance process.

History. Acts 2003, No. 657, § 1.

20-7-132. Guidelines for cleanup of clandestine methamphetamine labs.

(a) The Department of Health shall develop guidelines for the cleanup of former clandestine methamphetamine drug labs.

(b) The guidelines shall be made available on the department's website and shall be available to law enforcement officials and the public upon request.

(c) The guidelines shall be reviewed and updated annually.

History. Acts 2003, No. 1270, § 1.

2003, No. 1270, subsection (a) ended: "by

Publisher's Notes. As enacted by Acts April 1, 2004."

20-7-133. Child Health Advisory Committee — Creation.

(a) There is created a Child Health Advisory Committee to consist of twenty (20) members.

(b)(1) The Director of the Department of Health shall appoint:

(A) One (1) member to represent the Department of Health;

(B) One (1) member to represent the Arkansas Academy of Nutrition and Dietetics;

(C) One (1) member to represent the American Academy of Pediatrics, Arkansas Chapter;

(D) One (1) member to represent the Arkansas Academy of Family Practice;

(E) One (1) member to represent the Arkansas Association for Health, Physical Education, Recreation and Dance;

(F) One (1) member to represent jointly the American Heart Association, the American Cancer Society, and the American Lung Association;

(G) One (1) member to represent the Fay W. Boozman College of Public Health of the University of Arkansas for Medical Sciences;

(H) One (1) member to represent the Arkansas Center for Health Improvement;

(I) One (1) member to represent the Arkansas Advocates for Children and Families;

(J) One (1) member to represent the University of Arkansas Cooperative Extension Service; and

(K) One (1) member to represent the Office of Minority Health and Health Disparities of the Department of Health.

(2) The Commissioner of Education shall appoint:

(A) One (1) member to represent the Department of Education;

(B) One (1) member to represent the Arkansas School Nutrition Association;

(C) One (1) member to represent the Arkansas School Nurses Association;

(D) One (1) member to represent the Arkansas Association of Educational Administrators;

(E) One (1) member to represent the Arkansas Parent Teacher Association;

(F) One (1) member to represent the Arkansas School Boards Association;

(G) One (1) member to represent the Arkansas Association of School Business Officials;

(H) One (1) member to represent the Arkansas Association for Supervision and Curriculum Development; and

(I) One (1) member who is a classroom teacher.

(c) Terms of committee members shall be three (3) years except for the initial members, whose terms shall be determined by lot so as to stagger terms to equalize as nearly as possible the number of members to be appointed each year.

(d) If a vacancy occurs, the officer who made the original appointment shall appoint a person who represents the same constituency as the member being replaced.

(e) The committee shall elect one (1) of its members to act as chair for a term of one (1) year.

(f) A majority of the members shall constitute a quorum for the transaction of business.

(g) The committee shall meet at least monthly.

(h) The Department of Health shall provide office space and staff for the committee.

(i) Members of the committee shall serve without pay but may receive expense reimbursement in accordance with § 25-16-902 if funds are available.

History. Acts 2003, No. 1220, § 1;
2007, No. 719, § 1.

20-7-134. Powers and duties.

(a) The Child Health Advisory Committee shall meet at least one (1) time per month and make recommendations to the State Board of Education and the State Board of Health consistent with the intent and purpose of this section and §§ 20-7-133 and 20-7-135.

(b) The committee shall develop nutrition and physical activity standards and policy recommendations with consideration of the following:

(1) Foods sold individually in school cafeterias but outside the regulated National School Lunch Program;

(2) Competitive foods as defined by the United States Department of Agriculture as the definition is in existence on January 1, 2015, and offered at schools typically through vending machines, student stores, school fundraisers, food carts, or food concessions;

(3) The continuing professional development of food service staff;

(4) The expenditure of funds derived from competitive food and beverage contracts;

(5) Physical education and activity;

(6) Systems to ensure the implementation of nutrition and physical activity standards; and

(7) The monitoring and evaluating of results and reporting of outcomes.

(c) The committee shall examine the progress of the Arkansas Coordinated School Health Program and make recommendations to the Department of Education and the Department of Health concerning the implementation of the Arkansas Coordinated School Health Program.

History. Acts 2003, No. 1220, § 1; substituted “January 1, 2015” for “January 1, 2003” in (b)(2).
2007, No. 719, § 1; 2015, No. 846, § 36.

Amendments. The 2015 amendment

20-7-135. Nutrition and physical activity standards — Implementation.

(a) After having consulted the Child Health Advisory Committee and the State Board of Health, the State Board of Education shall promulgate appropriate rules and regulations to ensure that nutrition and physical activity standards and body mass index for age assessment protocols are implemented to provide students with the skills, opportunities, and encouragement to adopt healthy lifestyles.

(b) The Department of Health in consultation with the Department of Education shall:

(1) Employ one (1) qualified community health promotion professional with training or experience, or both, in nutrition, chronic disease, or another related field to be housed within the Department of Health to plan, develop, implement, and evaluate pilot or model programs to support schools and communities if funds are available;

(2) Employ one (1) statewide health promotion consultant to be housed within the Department of Education if funds are available;

(3) Employ one (1) person as a community health promotion specialist to support implementation of pilot or model programs in schools and communities in nutrition and physical activity in several distinct geographical areas of the state if funds are available;

(4) Assign all community health nurses under its supervision to work with schools to assure that body mass index for age assessment

protocols are followed by school employees or their designees who conduct body mass index for age assessments and other student health screenings; and

(5) Not use more than five percent (5%) of the annual Department of Health Master Settlement Agreement funds for the salaries or programs created under this subsection.

(c) Every school district shall:

(1) Prohibit for elementary school students in-school access to vending machines offering food and beverages;

(2) Require schools to include as part of the annual report to parents and the community the amounts and specific sources of funds received and expenditures made from competitive food and beverage contracts;

(3) Beginning with kindergarten and then in even-numbered grades, require schools to include as a part of a student health report to parents a body mass index percentile by age for each student; and

(4)(A) Permit any parent to refuse to have his or her child's body mass index percentile for age assessed and reported, by providing a written refusal to the school.

(B) Students in grades eleven (11) and twelve (12) are exempt from any policy or requirement of a public school or the state for measuring or reporting body mass index.

(d) The Department of Education shall:

(1) Begin the implementation of standards developed by the committee and approved by the Department of Education; and

(2) Annually monitor and evaluate the implementation and effectiveness of the nutrition and physical education standards.

(e) Every school district shall:

(1) Convene a school nutrition and physical activity advisory committee that shall include members from school district governing boards, school administrators, food service personnel, teacher organizations, parents, students, and professional groups such as nurses and community members to:

(A) Help raise awareness of the importance of nutrition and physical activity; and

(B) Assist in the development of local policies that address issues and goals, including but not limited to the following:

(i) Assisting with the implementation of nutrition and physical activity standards developed by the school nutrition and physical activity advisory committee with the approval of the Department of Education and the State Board of Health;

(ii) Integrating nutrition and physical activity into the overall curriculum;

(iii) Ensuring that professional development for staff includes nutrition and physical activity issues;

(iv) Ensuring that students receive nutrition education and engage in healthful levels of vigorous physical activity;

(v) Improving the quality of physical education curricula and increasing training of physical education teachers;

- (vi) Enforcing existing physical education requirements; and
- (vii) Pursuing contracts that both encourage healthy eating by students and reduce school dependence on profits from the sale of foods of minimal nutritional value;
- (2) Begin the implementation of standards developed by the committee with the approval of the Department of Education and the State Board of Health; and
- (3) Require that goals and objectives for nutrition and physical activity be incorporated into the annual school planning and reporting process.
- (f)(1) The Department of Education and the Department of Health shall report annually on progress in implementing nutrition and physical education standards to the:
 - (A) Chair of the House Committee on Public Health, Welfare, and Labor;
 - (B) Chair of the Senate Committee on Public Health, Welfare, and Labor;
 - (C) Chair of the House Committee on Education; and
 - (D) Chair of the Senate Committee on Education.
- (2) The State Board of Education shall submit to the House Committee on Education and the Senate Committee on Education for the committees' review any proposed rules regarding physical education or physical activity standards for grades kindergarten through twelve (K-12) developed pursuant to this section.

History. Acts 2003, No. 1220, § 1; 2003 (2nd Ex. Sess.), No. 29, § 1; 2007, No. 201, § 1; 2007, No. 317, § 3.

20-7-136. Statewide fluoridation program — Definition.

- (a) As used in this section, “water system” means a facility including without limitation a parent system, consecutive system, or other system that holds, treats, and supplies water directly or through a consecutive system or consecutive systems to five thousand (5,000) persons or more.
- (b) The company, corporation, municipality, county, government agency, or other entity that owns or controls a water system shall control the quantity of fluoride in the water so as to maintain a fluoride content established by the Department of Health.
- (c) The State Board of Health shall adopt rules relating to the fluoridation of water systems that shall include without limitation:
 - (1) Permissible concentrations of fluoride to be maintained by a water system; and
 - (2) Requirements and procedures for maintaining permissible concentrations of fluoride including without limitation:
 - (A) Necessary equipment;
 - (B) Recordkeeping;
 - (C) Reporting; and

(D) Testing.

(d)(1) A water system required to fluoridate under this section is not required to comply with the requirements of this section until funds sufficient to pay capital start-up costs for fluoridation equipment for the system have become available from any source other than tax revenue or service revenue regularly collected by the company, corporation, municipality, county, or other government agency that owns or controls the water system.

(2) A licensed civil engineer recognized or employed by the department who is familiar with the design, construction, operation, and maintenance of fluoridation systems shall determine for the department whether the capital start-up costs claimed under subdivision (d)(1) of this section are reasonable.

(e) A water system for a city in this state that receives its water supply from a community in another state is not required to comply with this section until a substantially similar fluoridation program is enacted for the water system of the community in the other state.

History. Acts 2011, No. 197, § 1.

20-7-137. Soccer goal safety — Definition.

(a)(1) As used in this section, “public recreation area” means an area that is used by members of the public for recreational activities.

(2) “Public recreation area” includes a privately owned or publicly owned:

- (A) Park;
- (B) Sports field;
- (C) Auditorium;
- (D) School playground; or
- (E) Other school facility.

(b) A soccer goal in a public recreation area shall be anchored according to the Guidelines for Movable Soccer Goal Safety promulgated by the United States Consumer Product Safety Commission as in effect on February 1, 2011, or the guidelines adopted by the Department of Health.

(c) The department shall develop and adopt guidelines for soccer goal safety as provided under this section.

History. Acts 2011, No. 772, § 2.

A.C.R.C. Notes. Acts 2011, No. 772, § 1, provided: “The General Assembly finds that:

“(1) On January 26, 2011, a tragic incident occurred when Jonathan Brian Nelson, who was nine (9) years of age, died of injuries sustained when an unanchored soccer goal fell on his head at Elm Tree Elementary School in Bentonville;

“(2) There are approximately five hundred thousand (500,000) soccer goals in the United States, and many of these soccer goals are unsafe because they are improperly designed, manufactured, or installed;

“(3) Problems arise with instability of movable soccer goals when they are unanchored, not properly anchored, or not properly counterbalanced;

“(4) Unstable soccer goals pose an unnecessary risk of tip-over to children who climb on the goals or nets or hang from the crossbar and can cause catastrophic injury to persons around the soccer goal;

“(5) There were at least nine (9) children under the age of sixteen (16) killed in accidents involving movable soccer goals between 1998 and mid-2010 and two thou-

sand (2,000) serious injuries during this same period, according to the United States Consumer Products Safety Commission; and

“(6) This act is necessary to ensure the safety of children around soccer goals at schools and other recreational areas in the state.”

20-7-138. [Repealed.]

Publisher's Notes. This section, concerning low voltage carbon monoxide detectors required in new home construc-

tion, was repealed by Act 2013, No. 565, § 1. The section was derived from Acts 2011, No. 146, § 1.

20-7-139. [Repealed.]

Publisher's Notes. This section, concerning rules for the home visitation program, was repealed by Acts 2017, No. 896,

§ 2. The section was derived from Acts 2013, No. 528, § 2.

SUBCHAPTER 2 — ARKANSAS HEALTH DEPARTMENT BUILDING AND LOCAL GRANT ACT

SECTION.

20-7-201. Title.

20-7-202. Definitions.

20-7-203. Disposition of funds.

20-7-204. State Health Department Building and Local Grant Trust Fund.

SECTION.

20-7-205. Rules and regulations — Application for grants.

20-7-206. Participation conditioned.

Publisher's Notes. Acts 1993, No. 350, § 7, provided: “(a) All powers, functions and duties heretofore vested in and exercised by the Health Building Commission are hereby transferred to and shall hereafter be vested in the State Board of Health.

“(b) All funds appropriated to and all property, both real and personal, vested in the Health Building Commission are hereby transferred and shall be made available to the State Board of Health.

“(c) The Health Building Commission is hereby abolished.”

Effective Dates. Acts 1991, No. 1162, § 15: Apr. 10, 1991. Emergency clause provided: “It is hereby found and determined by the General Assembly that the Arkansas Department of Health is critically in need of additional space and that, accordingly, the expansion, which is au-

thorized and enabled by this act, must be constructed as soon as feasible. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health and safety, shall be in force upon its passage and approval.”

Acts 1993, No. 350, § 11: Mar. 3, 1993. Emergency clause provided: “It is hereby found and determined by the General Assembly that the Arkansas Department of Health is critically in need of additional space and that, accordingly, the authorization to construct or acquire space enabled by this act, must be obtained as soon as feasible. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval.”

20-7-201. Title.

This subchapter may be known and may be cited as the “Arkansas Health Department Building and Local Grant Act”.

History. Acts 1989, No. 749, § 1.

20-7-202. Definitions.

As used in this subchapter:

(1)(A) “Acquire” means to lease, lease-purchase, or purchase any lands, buildings, structures, improvements, or other property, real, personal, or mixed.

(B) “Acquire” also includes payment or provision for payment of all expenses incidental thereto;

(2) “Board” means the State Board of Health;

(3)(A) “Construct” means to acquire, construct, reconstruct, renovate, remodel, install, and equip any lands, buildings, structures, improvements, or other property, real, personal, or mixed, useful in connection with any expansion or acquisition and to make other necessary expenditures in connection therewith by the methods and in the manner as may be authorized by law and in the case of an acquisition of equipment and other property of a medical, laboratory, or technical nature, by the method the Director of the Department of Health shall determine to be necessary or desirable to accomplish the power, purposes, and authorities set forth in this subchapter and without regard to the provisions of other laws pertaining to the construction and acquisition of property by state agencies.

(B) “Construct” also includes payment or provision for payment for all expenses incidental thereto;

(4) “Director” or “State Health Officer” means the Director of the Department of Health;

(5) “Department” means the Department of Health;

(6) “Fees” means all fees set forth in § 20-7-123(b), which are confirmed and ratified by this subchapter; and

(7) “Fund” means the State Health Department Building and Local Grant Trust Fund.

History. Acts 1989, No. 749, § 1; 1993, No. 350, § 1.

20-7-203. Disposition of funds.

(a) The Director of the Department of Health may construct or acquire such facilities and property as are necessary for the provision of current and future requirements for the Department of Health.

(b) Notwithstanding other provisions of this subchapter, the director, with the approval of the State Board of Health, may use any unobligated funds in the State Health Department Building and Local Grant Trust Fund in an amount not to exceed six hundred fifty thousand

dollars (\$650,000) to construct or acquire any land, building, structure, or other property, real, personal, or mixed, and any expenses incidental thereto which are deemed appropriate for the provision of current and future requirements for the department.

(c) With the approval of the board, the director may lease, sublease, or otherwise negotiate for the use of any space acquired or constructed under this subchapter to other governmental and nongovernmental entities. Revenues derived from any such lease, sublease, or other arrangement shall be deposited into the Public Health Fund.

(d) Neither the director nor any member of the board shall be personally liable for any obligation or action undertaken in connection therewith or for any damages sustained by anyone with respect to any obligations or actions unless he or she shall have acted with a corrupt intent.

History. Acts 1989, No. 749, § 1; 1991, No. 1162, § 14; 1993, No. 350, § 2.

20-7-204. State Health Department Building and Local Grant Trust Fund.

(a) There is established on the books of the Treasurer of State, Auditor of State, and Chief Fiscal Officer of the State a fund to be known as the “State Health Department Building and Local Grant Trust Fund”.

(b) The fund shall consist of such revenues as may be authorized by law, including a portion collected under § 20-7-129 and § 20-7-408(f).

(c) The Director of the Department of Health shall be the disbursing agent and executive officer for the fund.

(d) The fund shall be a continuing fund, not subject to fiscal year limitations, and, except as provided in § 20-7-203(b), shall only be used for expansion, renovation, construction, or improvements to the Department of Health building and for grants for construction, renovation, or other expansion of approved local health unit facilities in this state.

(e) No money from the fund may be used for the acquisition, purchase, lease, or otherwise, of real property for any local health unit facility.

History. Acts 1989, No. 749, § 1; 1993, No. 350, § 3; 2017, No. 206, § 3; 2017, No. 752, § 2.

Amendments. The 2017 amendment by No. 206 substituted “a portion collected

under § 20-7-129” for “the portion of client visit fees specified in § 20-7-127” in (b).

The 2017 amendment by No. 752 added “and § 20-7-408(f)” in (b).

20-7-205. Rules and regulations — Application for grants.

(a)(1) The State Board of Health may develop and implement rules and regulations to receive, review, and approve applications for grants

for new construction, renovation, or expansion of local health unit facilities from counties or cities.

(2) The board may adopt such rules and regulations as may be necessary to provide for the distribution of such funds for the renovation, construction, improvement, and development of the State Health Building.

(b) Except as provided in subsection (c) of this section, any grant approved by the board to a county or city for the development of a local public health facility project shall require ten percent (10%) local matching funds from the city or county applicant. The matching funds may be in the form of either cash or an in-kind match, to be determined by the board. The value of existing buildings and property shall not qualify for local matching funds under this section.

(c) The board may also establish by rule a special program to address renovation of local health units due to special requirements of the Department of Health. The programs shall provide for grants of up to ten thousand dollars (\$10,000). The local match may be waived for the special grants.

(d)(1) Application for grants under this subchapter shall be made in accordance with the rules and regulations of the board, and each application shall be considered on a needs-assessment basis.

(2) In addition, the applicant city or county shall furnish proof of the following with each grant application:

(A) Local community involvement in the project;

(B) Existence of resources to expand existing facilities, including availability of land;

(C) A design of the proposed project; and

(D) Evidence of need, including factors such as population growth, additional services to be offered, and increased workload.

History. Acts 1989, No. 749, § 1.

20-7-206. Participation conditioned.

Participation in the grant programs shall be conditioned on compliance with this subchapter and any rules or regulations of the State Board of Health promulgated under this subchapter.

History. Acts 1989, No. 749, § 1.

SUBCHAPTER 3 — STATE HEALTH DATA CLEARINGHOUSE ACT

SECTION.

20-7-301. Title.

20-7-302. Purpose.

20-7-303. Collection and dissemination of health data.

20-7-304. Release of health data.

20-7-305. State Board of Health to prescribe rules and regula-

SECTION.

tions — Data collected not subject to discovery.

20-7-306. Reports — Assistance.

20-7-307. Penalties.

20-7-308. Repealer.

20-7-309. List of substances used to alter samples in drug or alcohol

SECTION.

screening tests.

20-7-310. Construction with other laws.

A.C.R.C. Notes. References to “this subchapter” in §§ 20-7-301 — 20-7-308 may not apply to § 20-7-310, which was enacted subsequently.

Effective Dates. Acts 1997, No. 179, § 38: Feb. 17, 1997. Emergency clause provided: “It is hereby found and determined by the General Assembly that Act 10 of the First Extraordinary Session of 1995 abolished the Joint Interim Committee on Public Health, Welfare, and Labor and in its place established the House Interim Committee and Senate Interim Committee on Public Health, Welfare, and Labor; that various sections of the Arkansas Code refer to the Joint Interim Committee on Public Health, Welfare, and Labor and should be corrected to refer to the House and Senate Interim Committees on Public Health, Welfare, and Labor; that this act so provides; and that this act should go into effect immediately in order to make the laws compatible as soon as possible. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither

approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto.”

Acts 2003, No. 999, § 4[5]: Apr. 1, 2003. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that the federal District Courts for the Eastern and Western Districts of Arkansas have held the state’s school immunization statute to be unconstitutional, that the courts have stayed the effect of the finding, that if the stay is lifted before this act becomes effective, some students will be excluded from school attendance. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

20-7-301. Title.

This subchapter shall be entitled the “State Health Data Clearinghouse Act”.

History. Acts 1995, No. 670, § 1.

20-7-302. Purpose.

The General Assembly finds that as a result of rising healthcare costs, the shortage of health professionals and healthcare services in many areas of the state, and the concerns expressed by care providers, consumers, third-party payors, and others involved with planning for the provision of health care, there is an urgent need to understand patterns and trends in the availability, use, and costs of these services. Therefore, to establish an information base for patients, health professionals, and hospitals, to improve the appropriate and efficient usage of

healthcare services, and to provide for appropriate protection for confidentiality and privacy, the Department of Health shall act as a state health data clearinghouse for the acquisition and dissemination of data from state agencies and other appropriate sources to carry out this subchapter.

History. Acts 1995, No. 670, § 2.

20-7-303. Collection and dissemination of health data.

(a) With the approval of the State Board of Health, the Director of the Department of Health shall compile and disseminate health data collected by the Department of Health.

(b)(1) In consultation with advisory groups appointed by the director with representation from hospitals, outpatient surgery centers, health profession licensing boards, and other state agencies, the department should:

(A) Identify the most practical methods to collect, transmit, and share required health data as described in § 20-7-304;

(B) Utilize, wherever practical, existing administrative databases and modalities of data collection to provide the required data;

(C) Develop standards of accuracy, timeliness, economy, and efficiency for the provision of the data; and

(D) Ensure confidentiality of data by enforcing appropriate rules and regulations.

(2) To maximize limited resources and to prevent duplication of effort, the department may consider, when appropriate, contracting with private entities for the collection of data as set forth in this section subject to this subchapter.

(c)(1) All state agencies, including health profession licensing, certification, or registration boards and commissions, which collect, maintain, or distribute health data, including data relating to the Arkansas Medicaid Program, shall make available to the department such data as are necessary for the department to carry out its responsibilities under this subchapter or such rules and regulations as may be adopted as provided in § 20-7-305.

(2) If health data are already reported to another organization or governmental agency in the same manner, form, and content or in a manner, form, and content acceptable to the department, the director may obtain a copy of the data from the organization or agency, and no duplicate report need be submitted by the organization.

(3) All hospitals and outpatient surgery centers licensed by the state shall submit information in a form and manner as prescribed by rules and regulations by the State Board of Health pursuant to § 20-7-305. However, if the same information is being collected by another state agency, the department shall obtain the data from the other state agency.

History. Acts 1995, No. 670, § 2.

20-7-304. Release of health data.

The Director of the Department of Health may release data collected under this subchapter, except that data released shall not include any information which identifies or could be used to identify any individual patient, provider, institution, or health plan except as provided in § 20-7-305.

History. Acts 1995, No. 670, § 2.

20-7-305. State Board of Health to prescribe rules and regulations — Data collected not subject to discovery.

(a) The State Board of Health shall prescribe and enforce such rules and regulations as may be necessary to carry out this subchapter, including the manner in which data are collected, maintained, compiled, and disseminated, and including such rules as may be necessary to promote and protect the confidentiality of data reported under this subchapter.

(b) Data provided, collected, or disseminated under this subchapter which identifies, or could be used to identify, any individual patient, provider, institution, or health plan shall not be subject to discovery pursuant to the Arkansas Rules of Civil Procedure or the Freedom of Information Act of 1967, § 25-19-101 et seq.

(c)(1)(A) The Department of Human Services may provide data only for purposes of research and aggregate statistical reporting to the Arkansas Center for Health Improvement, the Agency for Healthcare Research and Quality for its Healthcare Cost and Utilization Project, or other researchers for research projects approved by the Department of Health under rules promulgated by the State Board of Health that provide for appropriate security and confidentiality protections for the data.

(B) The Department of Human Services also shall provide data to the Arkansas Hospital Association, Inc. for its price transparency and consumer-driven healthcare project that will make price and quality information about Arkansas hospitals available to the general public.

(2) The data shall be treated in a manner consistent with all state and federal privacy requirements, including, without limitation, the federal Health Insurance Portability and Accountability Act of 1996 privacy rule, specifically 45 C.F.R. § 164.512(i).

(3) Any identifiable data provided, collected, or disseminated under this subsection shall not be subject to discovery pursuant to the Arkansas Rules of Civil Procedure or the Freedom of Information Act of 1967, § 25-19-101 et seq.

(d) It shall be unlawful for the hospital or outpatient surgery center to release any patient-identifying information to any nongovernmental third party.

History. Acts 1995, No. 670, § 2; 2005, No. 1434, § 1; 2007, No. 616, § 1.

20-7-306. Reports — Assistance.

(a) The Director of the Department of Health shall prepare and submit a biennial report to the Governor and the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor or appropriate subcommittees thereof.

(b) The Department of Health shall provide assistance to the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor or appropriate subcommittees thereof in the development of information necessary in the examination of healthcare issues.

(c)(1) With regard to § 6-18-702(d), § 6-60-504(b), and § 20-78-206(a)(2)(B), the department shall report every six (6) months to the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor regarding:

(A) The geographic patterns of exemptions, vaccination rates, and exemptions in those areas as well as the rest of the state; and

(B) Disease incidence of vaccine-preventable diseases collected by the department.

(2) The collection of exemption information shall begin January 4, 2004.

(3) Reports shall begin at the first interim meeting of the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor.

History. Acts 1995, No. 670, § 2; 1997, No. 179, § 22; 2003, No. 999, § 4; 2007, No. 827, § 148.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of Requirements, 26 U. Ark. Little Rock L. Rev. 384.
Legislation, 2003 Arkansas General Assembly, Education Law, Immunization

20-7-307. Penalties.

(a)(1) Any person, firm, corporation, organization, or institution that violates any of the provisions of this subchapter or any rules and regulations promulgated under this subchapter regarding confidentiality of information shall be guilty of a Class C misdemeanor.

(2) Each day of violation shall constitute a separate offense.

(b) Any person, firm, corporation, organization, or institution knowingly violating any of the provisions of this subchapter or any rules and regulations promulgated under this subchapter shall be guilty of a violation and upon conviction shall be punished by a fine of not more than five hundred dollars (\$500).

(c)(1) Every person, firm, corporation, organization, or institution that violates any of the rules and regulations adopted by the State Board of Health or that violates any provision of this subchapter may be assessed a civil penalty by the board.

- (2) The civil penalty shall not exceed two hundred fifty dollars (\$250) for each violation.
- (3) However, no civil penalty may be assessed until the person charged with the violation has been given the opportunity for a hearing on the violation pursuant to the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

History. Acts 1995, No. 670, § 3; 2005, No. 1994, § 243.

20-7-308. Repealer.

All laws and parts of laws in conflict with this subchapter are repealed, except that nothing in this subchapter shall be interpreted to repeal any provision which authorizes the Health Services Permit Agency to gather such data as may be necessary to conduct permit-of-approval activities.

History. Acts 1995, No. 670, § 6.

20-7-309. List of substances used to alter samples in drug or alcohol screening tests.

The Department of Health shall maintain and update as part of its database under this subchapter a list of substances that may be used to adulterate urine or other bodily fluids that may be used in or used to interfere with a drug or alcohol screening test.

History. Acts 2003, No. 750, § 1.

20-7-310. Construction with other laws.

Nothing in this act shall be construed to encourage, conflict, or otherwise interfere with the preemption of state and local laws under any federal laws or United States Department of Transportation regulations related to drug testing procedures and confidentiality.

History. Acts 2003, No. 750, § 2.

Publisher’s Notes. References to “this subchapter” in §§ 20-7-301 — 20-7-308 may not apply to this section, which was enacted subsequently.

Acts 2003, No. 750, § 2, is also codified as § 5-60-202.

Meaning of “this act”. Acts 2003, No. 750, codified as §§ 5-60-201, 5-60-202, 20-7-309 and 20-7-310.

**SUBCHAPTER 4 — DEPARTMENT OF HEALTH PUBLIC HEALTH LABORATORY
ACT OF 2003**

- SECTION.
- 20-7-401. Title.
- 20-7-402. Purpose.
- 20-7-403. Definitions.
- 20-7-404. Approval of construction.
- 20-7-405. Financing of construction and renovation.

- SECTION.
- 20-7-406. Security for indebtedness.
- 20-7-407. Fees.
- 20-7-408. Disposition of certain fees.
- 20-7-409. State Board of Health Public Health Laboratory Construction Fund.

SECTION.

20-7-410. Investment of funds.

20-7-411. Formation of contracts.

SECTION.

20-7-412. Limitations on liability.

20-7-401. Title.

This subchapter shall be known and may be cited as the “Department of Health Public Health Laboratory Act of 2003”.

History. Acts 2003, No. 1723, § 1.

20-7-402. Purpose.

It is the purpose of this subchapter to better serve the citizens of Arkansas by providing for the construction and equipping of a modern public health laboratory.

History. Acts 2003, No. 1723, § 2.

20-7-403. Definitions.

As used in this subchapter:

- (1) “Authority” means the Arkansas Development Finance Authority;
- (2) “Authorizing resolution” means the resolution or resolutions adopted by the State Board of Health authorizing the loan;
- (3) “Board” means the State Board of Health;
- (4) “Building” means the state building of Department of Health located on West Markham Street in Little Rock;
- (5) “Construct” means to acquire, construct, reconstruct, remodel, install, and equip any lands, buildings, structures, improvements, or other property, whether real, personal, or mixed, useful in connection with the expansion, by any method and manner as may be authorized by law, and in the case of the acquisition of equipment and other property of a medical, laboratory, or technical nature, by any method as the board or the Director of the Department of Health determines to be necessary or desirable to accomplish the power, purposes, and authorities set forth in this subchapter and without regard to the provisions of other laws pertaining to the construction and acquisition of property by state agencies;
- (6) “Construction fund” means the State Board of Health Public Health Laboratory Construction Fund;
- (7) “Director” means the Director of the Department of Health;
- (8) “Fee revenues” means all revenues derived from all or any of the fees;
- (9) “Fees” means the fees generated under this subchapter that represent an increase to the allowable fees set forth in § 20-7-123;
- (10) “Laboratory” means a public health laboratory that is a modern stand-alone public health laboratory to be constructed on the existing site of the Department of Health located on West Markham Street in Little Rock;

(11) “Loan” means the loan which the board may effect from the authority by the terms of this subchapter;

(12) “Renovation” means the renovation and improvement of the building, including the renovation and alteration of existing properties, whether real, personal, or mixed;

(13) “Revenue fund” means the State Board of Health Laboratory Revenue Fund; and

(14) “Revenue loan fund” means the State Board of Health Laboratory Revenue Loan Fund.

History. Acts 2003, No. 1723, § 3.

20-7-404. Approval of construction.

(a)(1) The laboratory shall be constructed subject to approval by the State Board of Health.

(2) The board may take such action as may be appropriate for the renovation of the building and any facilities necessarily related to the building.

(b) Subject to the approval of the board, the plans, specifications, and estimates of cost for the laboratory and renovation of the building shall be developed by the Director of the Department of Health, and the director may employ architects and other like professional and technical assistance as determined to be necessary for the construction of the laboratory and renovation of the building.

(c) The board and the director may take such action as may be appropriate for the construction of the laboratory and renovation of the building to accomplish the purposes of this subchapter and may engage legal, technical, and other assistance as necessary.

History. Acts 2003, No. 1723, § 4.

20-7-405. Financing of construction and renovation.

(a)(1) To finance the construction of the laboratory and renovation of the building, the State Board of Health may enter into a loan from the Arkansas Development Finance Authority in the principal amount of not more than twenty-six million dollars (\$26,000,000) under the Arkansas Development Finance Authority Act, § 15-5-101 et seq., § 15-5-201 et seq., and § 15-5-301 et seq.

(2) The amount and purpose of the loan shall be approved by the board in an authorizing resolution, copies of which shall be maintained in the records of the board and of the authority.

(b) The loan shall bear interest at a rate determined by the rate of interest on funds borrowed by the authority to fund the loan but not to exceed the lesser of ten percent (10%) per annum or the maximum rate of interest permitted by the Arkansas Constitution.

(c) The loan shall mature over a period of not more than thirty (30) years.

(d) The board and the Director of the Department of Health may execute and deliver agreements, instruments, and other undertakings and writings and take such action as may be appropriate to evidence the loan and the security for the loan and to carry out this subchapter.

History. Acts 2003, No. 1723, § 5.

20-7-406. Security for indebtedness.

(a) The payment and other obligations of the State Board of Health under and with respect to the loan shall be secured by a pledge of the fee revenues, subject to the terms of this subchapter and the reserved power to release fee revenues as set forth in this subchapter.

(b) The loan shall be an obligation of the board only and shall not constitute an indebtedness for which the faith and credit of the State of Arkansas or any of its revenues are pledged.

(c) The loan shall not be secured by a lien on any land, building, or other property belonging to the State of Arkansas.

(d) The loan shall not constitute an indebtedness within the meaning of any constitutional or statutory limitation.

History. Acts 2003, No. 1723, § 6.

20-7-407. Fees.

In addition to the fees authorized by § 20-7-123(b)(1)(H) and (I), the following fees shall be collected and credited to the State Board of Health Laboratory Revenue Fund:

(1) A fee of seven dollars (\$7.00) collected by the State Registrar of Vital Records for the making and certification of any birth certificate or record;

(2) A fee of five dollars (\$5.00) collected for the making and certification of each additional copy of any birth certificate or record;

(3) A fee of six dollars (\$6.00) collected by the registrar for the making and certification of a single copy of a death certificate;

(4) A fee of seven dollars (\$7.00) collected by the registrar for the making and certification of each additional copy of a death certificate;

(5) A fee of five dollars (\$5.00) collected by the registrar for the making and certification of any marriage or divorce certificate or record;

(6) A fee of five dollars (\$5.00) collected by the registrar for the making and certification of each additional copy of any marriage or divorce certificate or record;

(7) A fee of seven dollars (\$7.00) collected by the registrar for an examination and search of the files for any birth record;

(8) A fee of five dollars (\$5.00) collected by the registrar for an examination and search of the files for any marriage or divorce record; and

(9) A fee of six dollars (\$6.00) collected by the registrar for an examination and search of the files for any death record.

History. Acts 2003, No. 1723, § 7.

2003, No. 1723, subsection (a) began: “Ef-

Publisher’s Notes. As enacted by Acts

fective September 1, 2003.”.

20-7-408. Disposition of certain fees.

(a)(1) Except as set forth in this subchapter, all fee revenues shall be treated as cash funds and shall not be deposited into the State Treasury, but shall be deposited as and when received into a bank or banks approved by the State Board of Health or the Director of the Department of Health in an account or accounts of the board designated the “State Board of Health Laboratory Revenue Fund”.

(2) So long as the loan is outstanding, all moneys in the State Board of Health Laboratory Revenue Fund shall not be subject to the provisions of §§ 19-4-801 — 19-4-803, 19-4-804 [repealed], 19-4-805, 19-4-806 and shall be deposited, handled, and disbursed as set forth in this subchapter.

(b) Moneys held in the State Board of Health Laboratory Revenue Fund shall be withdrawn and deposited no less frequently than bimonthly as follows and in the following order of priority:

(1) An annual amount sufficient to provide for principal, interest, servicing fees, and reserve requirements with respect to the loan but not to exceed two million six hundred thousand dollars (\$2,600,000) per fiscal year:

(A) Before the commencement of the loan, in the State Board of Health Public Health Laboratory Construction Fund; and

(B) Beginning upon commencement of the loan, in an account or accounts in the name of the board or the Arkansas Development Finance Authority, as determined by the board and the authority, designated the “State Board of Health Laboratory Revenue Loan Fund”; and

(2) Any balance remaining shall be distributed fifty percent (50%) to the Public Health Fund and fifty percent (50%) to the State Health Department Building and Local Grant Trust Fund.

(c)(1) All funds held in the State Board of Health Laboratory Revenue Fund, the State Board of Health Laboratory Revenue Loan Fund, and the State Board of Health Public Health Laboratory Construction Fund shall be deemed to be cash funds, shall not be deposited into the State Treasury, and shall be transferred, deposited, and applied as set forth in this subchapter without the necessity of appropriation.

(2) All transfers from the State Board of Health Laboratory Revenue Fund and the State Board of Health Public Health Laboratory Construction Fund shall be made by or at the direction of the director.

(3) All transfers from the State Board of Health Laboratory Revenue Loan Fund shall be made by:

(A) The director; or

(B) The authority, if approved by the board.

(d) So long as the loan is outstanding, funds held in the State Board of Health Laboratory Revenue Loan Fund shall be used solely for the purpose of paying and providing for the principal of, interest on, and

servicing fees, if any, in connection with the loan and providing for the creation and maintenance of necessary reserves. The funds may be pledged by the board to secure the loan and may be pledged and used by the authority to pay and secure bonds issued by the authority to finance the construction.

(e)(1) So long as the loan is outstanding, all fees shall be imposed and all fee revenues shall be collected and applied as provided in this subchapter.

(2) However, particular fees may be reduced or eliminated so long as remaining fees are increased or new fees are added to the end that the aggregate annual amount of fee revenues shall always equal at least three million dollars (\$3,000,000).

(f) Upon payment or discharge of the loan and all bonds issued by the authority under this subchapter, the fees authorized by this subchapter shall be deposited into the State Health Department Building and Local Grant Trust Fund.

History. Acts 2003, No. 1723, § 8; substituted “be deposited into the State Health Department Building and Local Grant Trust Fund” for “terminate” in (f).

Amendments. The 2017 amendment

20-7-409. State Board of Health Public Health Laboratory Construction Fund.

The proceeds of the loan other than amounts required to establish reserves, to pay interest on the loan for a period not to exceed one (1) year, or to pay costs of the loan and of issuing bonds, all of which shall be set forth in written directions executed by the Director of the Department of Health, shall be deposited as cash funds into an account of the State Board of Health designated the “State Board of Health Public Health Laboratory Construction Fund” and disbursed by the director for the construction of the expansion.

History. Acts 2003, No. 1723, § 9.

20-7-410. Investment of funds.

(a) All moneys held at any time in the State Board of Health Laboratory Revenue Fund and the State Board of Health Public Health Laboratory Construction Fund shall be invested and reinvested to the extent feasible, as directed by the Director of the Department of Health.

(b) All moneys held in the State Board of Health Laboratory Revenue Loan Fund shall be invested and reinvested to the extent feasible, as directed by the Arkansas Development Finance Authority, in securities which are eligible for the securing of public deposits under § 19-8-203, subject in all cases to the term of the loan and of bonds issued by the authority.

History. Acts 2003, No. 1723, § 10.

20-7-411. Formation of contracts.

- (a) The authorizing resolution and each agreement or other writing executed and delivered pursuant to it or to this subchapter, together with this subchapter, shall constitute a contract between the State Board of Health and the Arkansas Development Finance Authority, and the obligations of the board may be enforced by mandamus or other equitable or legal remedy.
- (b) The obligations of the board shall be freely assignable by the authority, provided that the board is notified in writing of the assignment.

History. Acts 2003, No. 1723, § 11.

20-7-412. Limitations on liability.

Neither the Director of the Department of Health nor any member of the State Board of Health shall be personally liable on the loan or on account of any of the obligations or actions undertaken in connection with the loan, or for any damages sustained by anyone with respect to the obligations or actions, unless he or she acted with a corrupt intent.

History. Acts 2003, No. 1723, § 12.

SUBCHAPTER 5 — ARKANSAS HEALTH-CONSCIOUS SHOPPER ACT

SECTION.	SECTION.
20-7-501. Title.	20-7-504. Department of Health —
20-7-502. Findings — Intent.	Guidelines.
20-7-503. Arkansas Health-Conscious Shopper Program.	

20-7-501. Title.

This subchapter shall be known and may be cited as the “Arkansas Health-Conscious Shopper Act”.

History. Acts 2007, No. 48, § 1.

20-7-502. Findings — Intent.

- (a) The General Assembly finds that shopping cart handles may be contaminated with bodily fluids such as blood, saliva, mucus, and even urine and fecal matter.
- (b) This subchapter is intended to:
- (1) Increase awareness of Arkansas shoppers, infants, and young children about potential contamination from contact with a shopping cart handle;
 - (2) Provide a barrier of protection between a shopper and a shopping cart handle; and
 - (3) Prevent the spread of viruses or bacteria.

History. Acts 2007, No. 48, § 1.

20-7-503. Arkansas Health-Conscious Shopper Program.

(a) There is created the Arkansas Health-Conscious Shopper Program.

(b) Under the program, each Arkansas business that uses shopping carts or infant carriers is encouraged to voluntarily provide consumers with sanitation wipes at the entrance of its business on or before January 1, 2008.

History. Acts 2007, No. 48, § 1.

20-7-504. Department of Health — Guidelines.

The Department of Health shall develop guidelines for businesses in the appropriate types and use of sanitation wipes for shopping cart handles.

History. Acts 2007, No. 48, § 1.

SUBCHAPTER 6 — PRESCRIPTION DRUG MONITORING PROGRAM ACT

SECTION.

- 20-7-601. Title.
- 20-7-602. Purpose.
- 20-7-603. Definitions.
- 20-7-604. Requirements for Prescription Drug Monitoring Program.
- 20-7-605. Prescription Drug Monitoring Program Advisory Committee — Creation — Members.
- 20-7-606. Confidentiality.
- 20-7-607. Providing prescription monitoring information.

SECTION.

- 20-7-608. Information exchange with other prescription drug monitoring programs.
- 20-7-609. Authority to contract.
- 20-7-610. Authority to seek funding.
- 20-7-611. Unlawful acts and penalties.
- 20-7-612. Privacy rights protected.
- 20-7-613. Rules.
- 20-7-614. Effective date.
- 20-7-615. Prescriber with a prescription drug violation.

RESEARCH REFERENCES

Ark. L. Rev. Frankie M. Griffin, M.D., Legislative Balance, 68 Ark. L. Rev. 913 Prescription Opioids in Arkansas: Finding (2016).

20-7-601. Title.

This subchapter shall be known and may be cited as the “Prescription Drug Monitoring Program Act”.

History. Acts 2011, No. 304, § 1.

20-7-602. Purpose.

The purpose of this subchapter is to protect the state health system and the citizens of Arkansas by:

(1) Enhancing patient care by providing prescription monitoring information that will ensure legitimate use of controlled substances in health care, including palliative care, research, and other medical pharmacological uses;

(2) Helping curtail the misuse and abuse of controlled substances;

(3) Assisting in combating illegal trade in and diversion of controlled substances; and

(4) Enabling access to prescription information by practitioners, law enforcement agents, and other authorized individuals and agencies and to make prescription information available to practitioners, law enforcement agents, and other authorized individuals and agencies in other states.

History. Acts 2011, No. 304, § 1.

20-7-603. Definitions.

As used in this subchapter:

(1)(A) “Arkansas Medicaid prescription drug program” means the prescription drug program that is a portion of the Title XIX Medicaid program for the State of Arkansas.

(B) The Arkansas Medicaid prescription drug program includes any entity contracted with the Arkansas Medicaid prescription drug program and to which the Arkansas Medicaid Program has granted authority;

(2) “Certified law enforcement prescription drug diversion investigator” means a certified law enforcement officer assigned by his or her law enforcement agency to investigate prescription drug diversion and who has completed a certification course in prescription drug diversion approved by the Prescription Drug Monitoring Program Advisory Committee and certified by the Arkansas Commission on Law Enforcement Standards and Training;

(3) “Controlled substance” means a drug, substance, or immediate precursor in Schedules II-V;

(4) “Dispense” means to deliver a controlled substance to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including without limitation the prescribing, administering, packaging, labeling, or compounding necessary to prepare the controlled substance for that delivery;

(5)(A) “Dispenser” means a practitioner who dispenses.

(B) “Dispenser” does not include:

(i) A licensed hospital pharmacy when it is distributing controlled substances for the purpose of outpatient services, inpatient hospital care, or at the time of discharge from a hospital, except for a pharmacy owned by a hospital that has a retail pharmacy permit

when the pharmacy is distributing controlled substances directly to the public;

(ii) A wholesale distributor of Schedules II-V controlled substances; or

(iii) A practitioner or other authorized person who administers a controlled substance;

(6) "Exchangeability" means the ability of the program to electronically share reported information with another state's prescription monitoring program if the information concerns the dispensing of a controlled substance either:

(A) To a patient who resides in the other state; or

(B) Prescribed by a practitioner whose principal place of business is located in the other state;

(7) "Investigation" means an active inquiry that is being conducted with a reasonable, good-faith belief that the inquiry:

(A) Could lead to the filing of administrative, civil, or criminal proceedings; or

(B) Is ongoing and continuing and a reasonable, good-faith anticipation exists for securing an arrest or prosecution in the foreseeable future;

(8) "Opioid" means a drug or medication that relieves pain, including without limitation:

(A) Hydrocodone;

(B) Oxycodone;

(C) Morphine;

(D) Codeine;

(E) Heroin; and

(F) Fentanyl;

(9) "Patient" means the person or animal who is the ultimate user of a controlled substance for whom a lawful prescription is issued and for whom a controlled substance is lawfully dispensed;

(10) "Practitioner" means:

(A) A physician, dentist, veterinarian, advanced practice nurse, physician assistant, pharmacist, scientific investigator, or other person licensed, registered, or otherwise permitted to prescribe, distribute, dispense, conduct research with respect to, or to administer a controlled substance in the course of professional practice or research in this state; and

(B) A pharmacy, hospital, or other institution licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, or to administer a controlled substance in the course of professional practice or research in this state;

(11) "Prescribe" means to issue a direction or authorization, by prescription, permitting a patient lawfully to obtain a controlled substance;

(12) "Prescriber" means a practitioner or other authorized person who prescribes a Schedule II, III, IV, or V controlled substance;

(13) "Prescription" means a controlled substance lawfully prescribed and subsequently dispensed;

(14) “Prescription drug monitoring program” means a program that collects, manages, analyzes, and provides information regarding Schedule II, III, IV, and V controlled substances as provided under the Uniform Controlled Substances Act, § 5-64-101 et seq., §§ 5-64-1101 — 5-64-1103, the Food, Drug, and Cosmetic Act, § 20-56-201 et seq., or §§ 20-64-501 — 20-64-513;

(15) “Qualified law enforcement agency” means a law enforcement agency that has a certified law enforcement prescription drug diversion investigator and a chief, sheriff, or law enforcement chief executive officer who has successfully completed a certification course in prescription drug diversion approved by the commission;

(16) “Schedule II” means controlled substances that are placed in Schedule II under § 5-64-205;

(17) “Schedule III” means controlled substances that are placed in Schedule III under § 5-64-207;

(18) “Schedule IV” means controlled substances that are placed in Schedule IV under § 5-64-209;

(19) “Schedule V” means controlled substances that are placed in Schedule V under § 5-64-211; and

(20) “Ultimate user” means a person who lawfully possesses a controlled substance for:

(A) The person’s own use;

(B) The use of a member of the person’s household; or

(C) Administering to an animal owned by a person or by a member of the person’s household.

History. Acts 2011, No. 304, § 1; 2015, No. 901, § 1; 2015, No. 1208, § 2; 2017, No. 46, § 1.

Amendments. The 2015 amendment by No. 901 added the definitions for “Certified law enforcement prescription drug diversion investigator” and “Qualified law enforcement agency”.

The 2015 amendment by No. 1208 added the definition for “Opiod”.

The 2017 amendment added the definition for “Arkansas Medicaid prescription drug program”.

20-7-604. Requirements for Prescription Drug Monitoring Program.

(a) The State Board of Health shall create the Prescription Drug Monitoring Program upon the Department of Health’s procuring adequate funding to establish the program.

(b)(1) Each dispenser shall submit to the department information regarding each controlled substance dispensed.

(2) A dispenser located outside Arkansas and licensed and registered by the Arkansas State Board of Pharmacy shall submit to the department information regarding each controlled substance prescription dispensed to an ultimate user whose address is within Arkansas.

(3) The State Board of Health shall create a controlled substances database for the Prescription Drug Monitoring Program.

(c) Each dispenser required to report under subsection (b) of this section shall submit to the department by electronic means information that shall include without limitation:

- (1) The dispenser's identification number;
- (2) The date the prescription was filled;
- (3) The prescription number;
- (4) Whether the prescription is new or is a refill;
- (5) The National Drug Code for the controlled substance that is dispensed;

- (6) The quantity of the controlled substance dispensed;
- (7) The number of days' supply dispensed;
- (8) The number of refills ordered;
- (9)(A) A patient identifier.

(B) A patient identifier shall not be a Social Security number or a driver's license number;

- (10) The patient's name;
- (11) The patient's address;
- (12) The patient's date of birth;
- (13) The patient's gender;
- (14) The prescriber's identification number;
- (15) The date the prescription was issued by the prescriber; and
- (16) The source of the payment for the prescription.

(d)(1) Except as required in subdivision (d)(2) of this section, practitioners are encouraged to access or check the information in the controlled substance database created under this subchapter before prescribing, dispensing, or administering medications.

(2)(A) A prescriber shall check the information in the Prescription Drug Monitoring Program when prescribing:

- (i) An opioid from Schedule II or Schedule III for every time prescribing the medication to a patient; and
- (ii) A benzodiazepine medication for the first time prescribing the medication to a patient.

(B) A licensing board that licenses practitioners who have the authority to prescribe shall adopt rules requiring the practitioners to check the information in the Prescription Drug Monitoring Program as described in subdivision (d)(2)(A) of this section.

(C) This subdivision (d)(2) does not apply to:

- (i) A practitioner administering a controlled substance:
 - (a) Immediately before or during surgery;
 - (b) During recovery from a surgery while in a healthcare facility;
 - (c) In a healthcare facility; or
 - (d) Necessary to treat the patient in an emergency situation at the scene of an emergency, in a licensed ground ambulance or air ambulance, or in the intensive care unit of a licensed hospital;
- (ii) A practitioner prescribing or administering a controlled substance to:
 - (a) A palliative care or hospice patient; or
 - (b) A resident in a licensed nursing home facility; or

(iii) Situations in which the Prescription Drug Monitoring Program is not accessible due to technological or electrical failure.

(D) The State Board of Health may amend, by rule, the exemptions listed in subdivision (d)(2)(C) of this section upon a recommendation from the Director of the Department of Health and a showing that the exemption or lack of exemption is unnecessarily burdensome or has created a hardship.

(3) A licensed oncologist shall check the Prescription Drug Monitoring Program when prescribing to a patient on an initial malignant episodic diagnosis and every three (3) months following the diagnosis while continuing treatment.

(e) This subchapter does not prohibit licensing boards from requiring practitioners to access or check the information in the controlled substance database as a part of a review of the practitioner's professional practice.

(f) Each dispenser shall submit the required information in accordance with transmission methods and frequency established by the department.

(g)(1) The department shall create a process for patients to address errors, inconsistencies, and other matters in their record as maintained under this section, including cases of breach of privacy and security.

(2) The department shall develop algorithms within the controlled substance database that would alert a practitioner if his or her patient is being prescribed opioids by more than three (3) physicians within any thirty-day period, if funding is available.

(h)(1) The department shall limit access to only those employees whose access is reasonably necessary to carry out this section.

(2) However, a prescriber may delegate access to the controlled substance database to persons under his or her supervision or employment.

(i) A certified law enforcement prescription drug diversion investigator shall provide to the department the following information in order to be granted access to the Prescription Drug Monitoring Program:

- (1) The identification credentials assigned by the department; and
- (2) The case number of the investigation.

(j)(1) A qualified law enforcement agency shall submit to the department an annual report of the data accessed by all certified law enforcement prescription drug diversion investigators in the qualified law enforcement agency, including without limitation:

(A) Written verification that the inquiries were part of a lawful prescription drug diversion investigation as provided to the department through the case number of the investigation; and

(B) The disposition of the investigation.

(2) The department shall:

(A) Create a verification form for use under subdivision (j)(1) of this section; and

(B) Make the verification form available annually to the qualified law enforcement agency.

(3)(A) The verification form under subdivision (j)(2) of this section shall be submitted to the department within thirty (30) days of receipt of the form by the qualified law enforcement agency.

(B) Failure to submit a verification form under subdivision (j)(3)(A) of this section shall result in the immediate suspension of access to the database by the qualified law enforcement agency and its certified law enforcement prescription drug diversion investigators until a determination is made by the department to allow continued access.

History. Acts 2011, No. 304, § 1; 2015, No. 901, § 2; 2015, No. 1208, §§ 3, 4; 2017, No. 820, § 1.

Amendments. The 2015 amendment by No. 901 added (i) and (j).

The 2015 amendment by No. 1208 inserted designation (g)(1); added (g)(2); in-

serted designation (h)(1); and added (h)(2).

The 2017 amendment redesignated former (d) as (d)(1); added "Except as required in subdivision (d)(2) of this section" in (d)(1); and added (d)(2) and (d)(3).

RESEARCH REFERENCES

Ark. L. Rev. Frankie M. Griffin, M.D., Legislative Balance, 68 Ark. L. Rev. 913 Prescription Opioids in Arkansas: Finding (2016).

20-7-605. Prescription Drug Monitoring Program Advisory Committee — Creation — Members.

(a) The Prescription Drug Monitoring Program Advisory Committee shall be created by the State Board of Health upon the Department of Health's procuring adequate funding to establish the Prescription Drug Monitoring Program.

(b) The mission of the committee is to consult with and advise the department on matters related to the establishment, maintenance, operation, and evaluation of the Prescription Drug Monitoring Program.

(c) The committee shall consist of:

(1) One (1) representative designated by each of the following organizations:

- (A) The Arkansas Academy of Physician Assistants, Inc.;
- (B) The Arkansas Association of Chiefs of Police;
- (C) The Arkansas Drug Director;
- (D) The Arkansas Medical Society, Inc.;
- (E) The Arkansas Nurses Association;
- (F) The Arkansas Optometric Association, Inc.;
- (G) The Arkansas Osteopathic Medical Association;
- (H) The Arkansas Pharmacist's Association;
- (I) The Arkansas Podiatric Medical Association, Inc.;
- (J) The Arkansas Prosecuting Attorneys Association;
- (K) The Arkansas Sheriffs' Association;
- (L) The Arkansas State Dental Association;
- (M) The Arkansas Veterinary Medical Association;
- (N) The State Board of Health; and

- (O) The Arkansas Public Defender Commission;
- (2) One (1) mental health provider or certified drug and alcohol counselor;
- (3) One (1) consumer appointed by the Governor;
- (4) The Chair of the Arkansas State Medical Board or his or her designee who is also a member of the Arkansas State Medical Board; and
- (5) The President of the Arkansas State Board of Dental Examiners or his or her designee who is also a member of the Arkansas State Board of Dental Examiners.

History. Acts 2011, No. 304, § 1; 2017, No. 820, § 4.

individual in (c)(2) is to be appointed.

A.C.R.C. Notes. It is unclear how the

Amendments. The 2017 amendment added (c)(4) and (c)(5).

20-7-606. Confidentiality.

(a) Prescription information submitted to the Department of Health under this subchapter is confidential and not subject to the Freedom of Information Act of 1967, § 25-19-101 et seq.

(b)(1) The controlled substances database created in this subchapter and all information contained in the controlled substances database and any records maintained by the Department of Health or by an entity contracting with the Department of Health that is submitted to, maintained, or stored as a part of the controlled substances database is privileged and confidential, is not a public record, and is not subject to subpoena or discovery in a civil proceeding.

(2) Information in the controlled substances database may be accessed by:

(A) A certified law enforcement officer pursuant to a criminal investigation but only after the law enforcement officer obtains a search warrant signed by a judge that demonstrates probable cause to believe that a violation of federal or state criminal law has occurred, that specified information contained in the database would assist in the investigation of the crime, and that the specified information should be released to the certified law enforcement officer;

(B) A regulatory body engaged in the supervision of activities of licensing or regulatory boards of practitioners authorized to prescribe or dispense controlled substances;

(C) A person or entity investigating a case involving breaches of privacy involving the database or its records;

(D) A certified law enforcement prescription drug diversion investigator of a qualified law enforcement agency;

(E) A practitioner within the Arkansas Medicaid prescription drug program; or

(F) The Department of Human Services or the Crimes Against Children Division of the Department of Arkansas State Police if:

(i) The purpose of the database access is related to an investigation under the Child Maltreatment Act, § 12-18-101 et seq., and not

pursuant to a criminal investigation by a certified law enforcement officer; and

(ii) The Department of Human Services has obtained a circuit court order to access the database under § 12-18-622.

(c) This section does not apply to information, documents, or records created or maintained in the regular course of business of a pharmacy, a medical, dental, optometric, or veterinary practitioner, or another entity covered by this subchapter, and all information, documents, or records otherwise available from original sources are not immune from discovery or use in a civil proceeding merely because the information contained in the records was reported to the controlled substances database under this subchapter.

(d) The Department of Health shall establish and enforce policies and procedures to ensure that the privacy and confidentiality of patients are maintained and that patient information collected, recorded, transmitted, and stored is protected and not disclosed to persons except as listed in § 20-7-607.

(e) The Prescription Drug Monitoring Program shall establish and maintain a process for verifying the credentials and authorizing the use of prescription information by individuals and agencies listed in § 20-7-607.

History. Acts 2011, No. 304, § 1; 2013, No. 1090, § 2; 2015, No. 901, § 3; 2015, No. 1161, § 5; 2017, No. 46, § 2.

Amendments. The 2013 amendment added (b)(2)(D).

The 2015 amendment by No. 901 inserted (b)(2)(D) and redesignated former (b)(2)(D) as (b)(2)(E).

The 2015 amendment by No. 1161, in (b)(2)(D)(ii) [now (b)(2)(F)(ii)], inserted “circuit” preceding “court” and substituted “12-18-622” for “12-18-604”.

The 2017 amendment inserted present (b)(2)(E); and redesignated former (b)(2)(E) as (b)(2)(F).

20-7-607. Providing prescription monitoring information.

(a)(1)(A)(i) The Department of Health shall review the Prescription Drug Monitoring Program information, including without limitation a review to identify information that appears to indicate whether a person is obtaining prescriptions in a manner that may represent misuse or abuse of controlled substances based on prescribing criteria determined by the Director of the Department of Health upon consultation with the Prescription Drug Monitoring Program Advisory Committee.

(ii) The prescribing criteria shall be posted on the website of the department and be available in print upon request.

(B) If the information appears to indicate misuse or abuse may have occurred, the department shall notify the practitioners and dispensers who have prescribed or dispensed in the following manner:

(i) The department shall provide quarterly reports to the individual practitioners and dispensers; and

(ii) If after twelve (12) months of providing quarterly reports to the practitioners and dispensers, the information appears to indicate misuse or abuse may be continuing, the department shall send a report to the licensing boards of the practitioner or dispenser who prescribed or dispensed the prescription.

(C) If information of misuse or abuse is identified, the department shall notify the practitioners and dispensers who prescribed or dispensed the prescriptions and the United States Diversion Control Division of the United States Drug Enforcement Administration.

(D) On or before January 1, 2019, the department shall contract with a vendor to make the Prescription Drug Monitoring Program interactive and to provide same-day reporting in real time, if funding and technology are available.

(2)(A) The department may review the Prescription Drug Monitoring Program information, including without limitation a review to identify information that appears to indicate whether a prescriber or dispenser may be prescribing or dispensing prescriptions in a manner that may represent misuse or abuse of controlled substances.

(B) If information of misuse or abuse is identified, the department may notify the professional licensing board of the prescriber or dispenser only after the relevant professional licensing board has provided the department with the parameters for triggering a notification from the department to the professional licensing board.

(b) The department shall provide information in the Prescription Drug Monitoring Program upon request and at no cost only to the following persons:

(1)(A) A person authorized to prescribe or dispense controlled substances for the purpose of providing medical or pharmaceutical care for his or her patients or for reviewing information regarding prescriptions that are recorded as having been issued or dispensed by the requester.

(B) An agent or employee of the prescriber or dispenser to whom the prescriber or dispenser has delegated the task of assessing the data described in this subsection, but only if the agent or employee has been granted access by a delegate account;

(2) A patient who requests his or her own prescription monitoring information;

(3) A parent or legal guardian of a minor child who requests the minor child's Prescription Drug Monitoring Program information;

(4)(A) A designated representative of a professional licensing board of the professions of the healing arts representing healthcare disciplines whose licensees are prescribers pursuant to an investigation of a specific individual, entity, or business licensed or permitted by the licensing board.

(B) Except as permitted by subdivision (a)(2) of this section, the department shall provide information under subdivision (b)(4)(A) of this section only if the requesting licensing board states in writing that the information is necessary for an investigation;

(5) The State Medical Examiner as authorized by law to investigate causes of deaths for cases under investigation pursuant to his or her official duties and responsibilities;

(6) Local, state, and federal law enforcement or prosecutorial officials engaged in the administration, investigation, or enforcement of the laws governing controlled substances required to be submitted under this subchapter pursuant to the agency's official duties and responsibilities; and

(7) Personnel of the department for purposes of administration and enforcement of this subchapter.

(c) Information collected under this subchapter shall be maintained for three (3) years.

(d) The department may provide patient, prescriber, or dispenser information to public or private entities for statistical, research, or educational purposes after encrypting or removing any patient's name, street name and number, patient identification number, month and day of birth, and prescriber or dispenser information that could be used to identify individual patients or persons who received prescriptions.

(e) The department may provide information in the Prescription Drug Monitoring Program to insurance carriers for the purpose of verifying prescriber or dispenser registration for individuals that are part of the health plan's network of providers.

History. Acts 2011, No. 304, § 1; 2015, No. 901, § 4; 2015, No. 1208, § 1; 2017, No. 688, §§ 1, 2; 2017, No. 820, § 2.

Amendments. The 2015 amendment by No. 901 added "and the Office of Diversion Control of the United States Drug Enforcement Administration" at the end of (a)(2) [now (a)(1)(C)].

The 2015 amendment by No. 1208 redesignated former (a)(1) as (a)(1)(A) and former (a)(2) as (a)(1)(B); added present (a)(2); inserted designation (b)(1)(A); and added (b)(1)(B).

The 2017 amendment by No. 688, in (d), inserted "patient, prescriber, or dispenser", substituted "any patient's" for

"the patient's", inserted "or dispenser", and deleted "from dispensers, or both" following "prescriptions" at the end; and added (e).

The 2017 amendment by No. 820 redesignated former (a)(1)(A) as (a)(1)(A)(i); in (a)(1)(A)(i), substituted "shall" for "may", substituted "is" for "may be", and added "based on prescribing criteria determined by the Director of the Department of Health upon consultation with the Prescription Drug Monitoring Program Advisory Committee"; added (a)(1)(A)(ii); inserted present (a)(1)(B); redesignated former (a)(1)(B) as (a)(1)(C); and added (a)(1)(D).

20-7-608. Information exchange with other prescription drug monitoring programs.

(a) The Department of Health may provide prescription monitoring information to other states' prescription drug monitoring programs, and the information may be used by those programs consistent with this subchapter.

(b) The department may request and receive prescription monitoring information from other states' prescription drug monitoring programs and may use the information under this subchapter.

(c) The department may develop the capability to transmit information to other prescription drug monitoring programs and receive information from other prescription drug monitoring programs employing the standards of exchangeability.

(d) The department may enter into written agreements with other states' prescription drug monitoring programs for the purpose of describing the terms and conditions for sharing prescription information under this subchapter.

History. Acts 2011, No. 304, § 1.

20-7-609. Authority to contract.

(a) The Department of Health may contract with another agency of this state or with a private vendor, as necessary, to ensure the effective operation of the Prescription Drug Monitoring Program.

(b) A contractor shall be bound to comply with the provisions regarding confidentiality of prescription information as outlined in this subchapter and shall be subject to the penalties specified in this subchapter for unlawful acts.

History. Acts 2011, No. 304, § 1.

20-7-610. Authority to seek funding.

(a) The Department of Health may make application for, receive, and administer grant funding from public or private sources for the development, implementation, or enhancement of the Prescription Drug Monitoring Program.

(b) A fee shall not be levied against practitioners for the purpose of funding or complying with the Prescription Drug Monitoring Program.

History. Acts 2011, No. 304, § 1.

20-7-611. Unlawful acts and penalties.

(a)(1) It is unlawful for a dispenser to purposely fail to submit prescription monitoring information as required under this subchapter.

(2) A violation of subdivision (a)(1) of this section is a Class B misdemeanor.

(b)(1) It is unlawful for a dispenser to purposely submit fraudulent prescription information.

(2) A violation of subdivision (b)(1) of this section is a Class D felony.

(c)(1) It is unlawful for a person authorized to receive prescription monitoring information to purposely disclose the information in violation of this subchapter.

(2) A violation of subdivision (c)(1) of this section is a Class C felony.

(d)(1) It is unlawful for a person authorized to receive prescription drug monitoring program information to use such information in a manner or for a purpose in violation of this subchapter.

(2) A violation of subdivision (d)(1) of this section is a Class C felony.

(e)(1) It is unlawful for a person to knowingly obtain, use, or disclose or attempt to obtain, use, or disclose information by fraud or deceit from the Prescription Drug Monitoring Program or from a person authorized to receive information from the Prescription Drug Monitoring Program under this subchapter.

(2) A violation of subdivision (e)(1) of this section is a Class C felony.

(f) In addition to the criminal penalties provided in this section, a dispenser or practitioner who uses or discloses confidential information received from the Prescription Drug Monitoring Program in a manner or for a purpose in violation of this subchapter may be subject to disciplinary action by the dispenser's or practitioner's licensing board.

(g) In addition to the criminal penalties provided in this section, a law enforcement officer who uses or discloses confidential information received from the Prescription Drug Monitoring Program in a manner or for a purpose in violation of this subchapter may be subject to disciplinary action by the law enforcement officer's agency or department.

(h) This subchapter does not limit a person whose privacy has been compromised unlawfully under this section from bringing a civil action to address the breach of privacy or to recover all damages to which the person may be entitled per violation, including attorney's fees and costs.

(i) A practitioner who purposely fails to access the Prescription Drug Monitoring Program as required by § 20-7-604(d) is subject to disciplinary action by the licensing board of the practitioner.

History. Acts 2011, No. 304, § 1; 2017, No. 820, § 3.

Amendments. The 2017 amendment added (i).

20-7-612. Privacy rights protected.

This subchapter does not give authority to any person, agency, corporation, or other legal entity to invade the privacy of any citizen as defined by the General Assembly, the courts, or the United States Constitution or the Arkansas Constitution other than to the extent provided in this subchapter.

History. Acts 2011, No. 304, § 1.

20-7-613. Rules.

The State Board of Health shall adopt rules to implement this subchapter.

History. Acts 2011, No. 304, § 1.

20-7-614. Effective date.

(a) The Prescription Drug Monitoring Program shall become operational March 1, 2013, if full funding is available under § 20-7-610.

(b) The Director of the Department of Health may suspend operation of the program if adequate funding under § 20-7-610 ceases.

History. Acts 2011, No. 304, § 1.

20-7-615. Prescriber with a prescription drug violation.

(a) A prescriber who has been found by his or her licensing board to be in violation of a rule or law involving prescription drugs shall be required by the appropriate licensing board to register with the Prescription Drug Monitoring Program and access patient information before writing a prescription for an opioid.

(b) The licensing board, in its discretion, may remove this requirement after a period of time if the licensing board deems removal of the requirement appropriate.

History. Acts 2015, No. 1208, § 5.

RESEARCH REFERENCES

Ark. L. Rev. Frankie M. Griffin, M.D., Legislative Balance, 68 Ark. L. Rev. 913
Prescription Opioids in Arkansas: Finding (2016).

SUBCHAPTER 7 — COMBATING PRESCRIPTION DRUG ABUSE ACT

SECTION.	SECTION.
20-7-701. Title.	20-7-704. Prescriber education.
20-7-702. Definitions.	20-7-705. Licensing board rules.
20-7-703. Opioid prescribing guidelines for emergency department.	20-7-706. Patient evaluation.
	20-7-707. Prescriber requirements.
	20-7-708. Immunity.

20-7-701. Title.

This subchapter shall be known and may be cited as the “Combating Prescription Drug Abuse Act”.

History. Acts 2015, No. 1208, § 6.

20-7-702. Definitions.

- As used in this subchapter:
- (1) “Chronic nonmalignant pain” means pain requiring more than three (3) consecutive months of prescriptions for:
 - (A) An opioid that is written for more than the equivalent of ninety (90) tablets, each containing five milligrams (5 mg) of hydrocodone;
 - (B) A morphine equivalent dose of more than fifteen milligrams (15 mg) per day; or
 - (C) In the specific case of tramadol, an average dose equivalent of two hundred milligrams (200 mg) or greater per day;
 - (2) “Hospital” means a healthcare facility licensed as a hospital by the State Board of Health under § 20-9-213;

(3) “Opioid” means a drug or medication that relieves pain, including without limitation:

- (A) Codeine;
- (B) Fentanyl;
- (C) Heroin;
- (D) Hydrocodone;
- (E) Morphine; and
- (F) Oxycodone; and

(4) “Prescriber” means a practitioner or other authorized person who prescribes a Schedule II, III, IV, or V controlled substance.

History. Acts 2015, No. 1208, § 6; two hundred milligrams (200 mg) or greater per day” for “a dose of fifty milligrams (50 mg) or one hundred twenty

Amendments. The 2017 amendment substituted “an average dose equivalent of (120) tablets” in (1)(C).

20-7-703. Opioid prescribing guidelines for emergency department.

(a) A hospital with an emergency department shall adopt guidelines concerning opioid prescribing in the emergency department.

(b) The guidelines shall be drafted jointly by the emergency department physicians and medical staff and approved by the governing body of the hospital.

(c) The guidelines shall address, at a minimum:

- (1) Treatment of chronic nonmalignant pain and acute pain;
- (2) Limits on amounts or duration of opioid prescriptions; and
- (3) Identification of situations where opioid prescriptions should be discouraged or prohibited.

(d) The guidelines shall not be construed as establishing a standard of care.

History. Acts 2015, No. 1208, § 6.

RESEARCH REFERENCES

Ark. L. Rev. Frankie M. Griffin, M.D., Legislative Balance, 68 Ark. L. Rev. 913
Prescription Opioids in Arkansas: Finding (2016).

20-7-704. Prescriber education.

(a)(1) Within the first two (2) years of being granted a license in the state, a prescriber shall obtain a minimum of two (2) hours of prescribing education approved by the appropriate licensing board.

(2) The education approved by the appropriate licensing board under subdivision (a)(1) of this section shall include:

- (A) Options for online and in-person programs; and
- (B) Information on prescribing rules, regulations, and laws that apply to individuals who are licensed in the state.

(b) This section shall apply to all prescribers licensed after December 31, 2015.

History. Acts 2015, No. 1208, § 6.

20-7-705. Licensing board rules.

(a) A licensing board that licenses individuals with prescriptive authority shall adopt rules that are at least as stringent as the rules of the Arkansas State Medical Board concerning use of narcotics for the treatment of pain not associated with malignant or terminal illness.

(b) A licensing board that licenses individuals who are authorized to prescribe opioids for treatment of chronic nonmalignant pain shall promulgate rules that contain, at a minimum, the requirements of § 20-7-707.

History. Acts 2015, No. 1208, § 6.

20-7-706. Patient evaluation.

A patient who is being treated with controlled substances for chronic nonmalignant pain shall be evaluated at least one (1) time every six (6) months by a physician who is licensed by the Arkansas State Medical Board.

History. Acts 2015, No. 1208, § 6.

RESEARCH REFERENCES

Ark. L. Rev. Frankie M. Griffin, M.D., Legislative Balance, 68 Ark. L. Rev. 913 Prescription Opioids in Arkansas: Finding (2016).

20-7-707. Prescriber requirements.

(a) For a patient with chronic nonmalignant pain, a prescriber, at a minimum and in addition to any additional requirements of the appropriate licensing board, shall:

(1) Check the prescriptive history of the patient on the Prescription Drug Monitoring Program at least every six (6) months; and

(2) Have a signed pain contract with the patient that states, at a minimum, the expectations of the prescriber for the behavior of the patient which may include:

(A) A requirement for random urine drug screenings to help ensure that the patient is abiding by the requirements of the contract; and

(B) A requirement for random pill counts to ensure compliance with the prescription.

(b) The requirements of this section shall not apply to a patient:

(1) Whose pain medications are being prescribed for a malignant condition;

(2) With a terminal condition;

(3) Who is a resident of a licensed healthcare facility;

(4) Who is enrolled in a hospice program; or

(5) Who is in an inpatient or outpatient palliative care program.

History. Acts 2015, No. 1208, § 6.

RESEARCH REFERENCES

Ark. L. Rev. Frankie M. Griffin, M.D., Legislative Balance, 68 Ark. L. Rev. 913
Prescription Opioids in Arkansas: Finding (2016).

20-7-708. Immunity.

A prescriber or licensed healthcare facility that in good faith reports a suspected drug diversion is immune from civil or criminal liability and disciplinary action by the appropriate licensing board.

History. Acts 2015, No. 1208, § 6.

CHAPTER 8

STATE HEALTH AGENCIES AND PROGRAMS

SUBCHAPTER.

1. HEALTH SERVICES PERMIT AGENCY.
2. ARKANSAS SPINAL CORD COMMISSION.
3. GREAT STRIDES GRANT PROGRAM.
4. HEALTH DATA INITIATIVE.
5. NEWBORN UMBILICAL CORD BLOOD INITIATIVE ACT.
6. ALZHEIMER'S ADVISORY COUNCIL. [EXPIRED.]
7. PALLIATIVE CARE.
8. VOLUNTEER HEALTH CARE ACT.

CASE NOTES

Cited: UHS of Ark., Inc. v. City of Sherwood, 296 Ark. 97, 752 S.W.2d 36 (1988).

SUBCHAPTER 1 — HEALTH SERVICES PERMIT AGENCY

SECTION.

- 20-8-101. Definitions.
- 20-8-102. Health Services Permit Commission — Creation — Members — Meetings.
- 20-8-103. Health Services Permit Commission — Powers and duties.
- 20-8-104. Health Services Permit Agency — Powers and duties.
- 20-8-105. Director.
- 20-8-106. Health Services Program — Permits generally.

SECTION.

- 20-8-107. Expansion of facilities or services.
- 20-8-108. Fees and fines.
- 20-8-109. Approval of new projects — Repeal of Acts 1975, No. 558, § 5 — Transfer of duties — Definition.
- 20-8-110. Collection and dissemination of health data.
- 20-8-111. Transfer of Developmental Disabilities Planning Council attributes to other agency.

SECTION.

20-8-112. Additional transfer of Developmental Disabilities Planning Council attributes to other agency.

SECTION.

20-8-113. Findings.

A.C.R.C. Notes. References to "this subchapter" in §§ 20-8-101 — 20-8-110 may not apply to §§ 20-8-111 — 20-8-113, which were enacted subsequently.

Publisher's Notes. Former subchapter 1 of this chapter, concerning state health planning and development, was partially repealed by Acts 1987, No. 593, § 10, which repealed former §§ 20-8-101 — 20-8-103 and 20-8-114. The remainder of the subchapter, §§ 20-8-104 — 20-8-113, was repealed by Acts 1987, No. 593, § 9, as amended by Acts 1987 (1st Ex. Sess.), No. 40, § 11. The former subchapter was derived from the following sources:

20-8-101. Acts 1975, No. 558, §§ 1, 2; 1981, No. 808, § 1; A.S.A. 1947, §§ 82-2307, 82-2308.

20-8-102. Acts 1975, No. 558, § 6; 1981, No. 808, § 4; 1985, No. 857, § 2; 1985, No. 948, § 2; A.S.A. 1947, § 82-2312.

20-8-103. Acts 1975, No. 558, § 3; 1981, No. 808, § 2; 1983, No. 131, §§ 1-3, 5; 1983, No. 135, §§ 1-3, 5; A.S.A. 1947, §§ 6-623 — 6-626, 82-2309.

20-8-104. Acts 1975, No. 558, § 5; 1981, No. 808, § 3; A.S.A. 1947, § 82-2311.

20-8-105. Acts 1975, No. 558, § 5; 1981, No. 808, § 3; A.S.A. 1947, § 82-2311.

20-8-106. Acts 1975, No. 558, § 5; 1981, No. 808, § 3; A.S.A. 1947, § 82-2311.

20-8-107. Acts 1975, No. 558, § 5; 1981, No. 808, § 3; A.S.A. 1947, § 82-2311.

20-8-108. Acts 1975, No. 558, § 5; 1981, No. 808, § 3; A.S.A. 1947, § 82-2311.

20-8-109. Acts 1975, No. 558, § 5; 1981, No. 808, § 3; 1985, No. 857, § 1; 1985, No. 948, § 1; A.S.A. 1947, § 82-2311.

20-8-110. Acts 1975, No. 558, § 5; 1981, No. 808, § 3; 1985, No. 857, § 1; 1985, No. 948, § 1; A.S.A. 1947, § 82-2311.

20-8-111. Acts 1975, No. 558, § 5; 1981, No. 808, § 3; 1985, No. 857, § 1; 1985, No. 948, § 1; A.S.A. 1947, § 82-2311.

20-8-112. Acts 1975, No. 558, § 5; 1981, No. 808, § 3; 1985, No. 857, § 1; 1985, No. 948, § 1; A.S.A. 1947, § 82-2311.

20-8-113. Acts 1975, No. 558, § 5; 1981, No. 808, § 3; A.S.A. 1947, § 82-2311.

20-8-114. Acts 1977, No. 831, §§ 1-3; A.S.A. 1947, §§ 82-2314 — 82-2316.

Effective Dates. Acts 1987, No. 593, § 13: Apr. 4, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that there is an immediate and urgent need to effect revisions in the health planning system of the State, health planning has a direct impact on the public health, welfare and safety; that an emergency is hereby declared to exist, and this Act is declared to be necessary for the preservation for the public peace, health and safety and shall become effective from and after its passage and approval."

Acts 1987 (1st Ex. Sess.), No. 40, § 15: June 19, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that Act 593 of 1987 contained technical errors and omissions which, if uncorrected, will result in the loss of federal dollars in assisting the elderly and needy population of this state with their health care needs; that an effective health planning system is needed in this state; that health planning has a direct impact on the public health, welfare and safety; that an emergency is hereby declared to exist, and this Act is declared to be necessary for the preservation for the public peace, health and safety and shall become effective from and after its passage and approval."

Acts 1989, No. 107, § 7: Feb. 20, 1989. Emergency clause provided: "It is hereby found and determined by the General Assembly that the state does not have a statewide clearing house for health data; that the establishment of such a clearing house is essential to adequately respond to the health needs of the citizens of the state; that this Act creates a statewide health data clearing house; and that the collection of health data should begin immediately. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1989, No. 533, § 4: Mar. 14, 1989. Emergency clause provided: "It is hereby

found and determined by the Seventy-Seventh General Assembly of the State of Arkansas that there is an immediate and urgent need to effect revisions in the health planning system of the state; that there are no promulgated regulations and there has been confusion regarding the issuance of permits for approval required for certain services, and that care to some patients has been interrupted. Therefore, an emergency is hereby declared to exist and this Act being immediately necessary for the preservation for the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Acts 1991, No. 623, § 6: Mar. 19, 1991. Emergency clause provided: "It is hereby found and determined by the Seventy-Eighth General Assembly that residential care facilities are now under the jurisdiction of the Health Service Commission; that representation on the commission by those covered by the commission is fundamental in a democratic society; that the immediate appointment of a representative on such commission is necessary to preserve the rights of those facilities being regulated by the commission. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect upon passage and approval."

Acts 1993, No. 821, § 13: July 1, 1993. Emergency clause provided: "It is hereby found and determined by the Seventy-Ninth General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness of this Act on July 1, 1993 is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1, 1993 could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 1993."

Acts 1995, No. 77, § 13: July 1, 1995. Emergency clause provided: "It is hereby

found and determined by the Eightieth General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness of this Act on July 1, 1995 is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1, 1995 could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 1995."

Acts 1997, No. 179, § 38: Feb. 17, 1997. Emergency clause provided: "It is hereby found and determined by the General Assembly that Act 10 of the First Extraordinary Session of 1995 abolished the Joint Interim Committee on Public Health, Welfare, and Labor and in its place established the House Interim Committee and Senate Interim Committee on Public Health, Welfare, and Labor; that various sections of the Arkansas Code refer to the Joint Interim Committee on Public Health, Welfare, and Labor and should be corrected to refer to the House and Senate Interim Committees on Public Health, Welfare, and Labor; that this act so provides; and that this act should go into effect immediately in order to make the laws compatible as soon as possible. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 1997, No. 250, § 258: Feb. 24, 1997. Emergency clause provided: "It is hereby found and determined by the General Assembly that Act 1211 of 1995 established the procedure for all state boards and commissions to follow regarding reim-

bursement of expenses and stipends for board members; that this act amends various sections of the Arkansas Code which are in conflict with the Act 1211 of 1995; and that until this cleanup act becomes effective conflicting laws will exist. Therefore an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 1997, No. 1025, § 6: Apr. 2, 1997. Emergency clause provided: "It is hereby

found and determined by the General Assembly that this act excludes certain transitional pediatric rehabilitation facilities from the permit of approval process; and that this act is immediately necessary to allow such facilities to proceed without delay. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

CASE NOTES

ANALYSIS

Legislative Intent.

Federal and State Requirements.

Legislative Intent.

The legislative intent of Acts 1987 (1st Ex. Sess.), No. 40, that there be a prospective moratorium on all licensing was clear; the reinstatement of the permit of approval requirement was also prospective, but it was not clearly intended to apply to applications which had been submitted while Act 593 of 1987 was in effect. *Scott v. Consolidated Health Mgt., Inc.*, 297 Ark. 601, 764 S.W.2d 434 (1989).

Federal and State Requirements.

The federal and state laws restricting hospital construction are not mere guidelines which the director of the state

agency is free to disregard. *Statewide Health Coordinating Council v. General Hosps. of Humana, Inc.*, 280 Ark. 443, 660 S.W.2d 906 (1983), cert. denied, 467 U.S. 1205, 104 S. Ct. 2386, 81 L. Ed. 2d 344 (1984) (decision under prior law).

The principal goals and objectives of the entire federal and state program restricting hospital construction are to reduce the cost of hospital care by prohibiting the construction of new hospitals that would exceed the bed-to-population limit. *Statewide Health Coordinating Council v. General Hosps. of Humana, Inc.*, 280 Ark. 443, 660 S.W.2d 906 (1983), cert. denied, 467 U.S. 1205, 104 S. Ct. 2386, 81 L. Ed. 2d 344 (1984) (decision under prior law).

Cited: *UHS of Ark., Inc. v. Charter Hosp. of Little Rock, Inc.*, 297 Ark. 8, 759 S.W.2d 204 (1988).

20-8-101. Definitions.

As used in this subchapter:

- (1) "Agency" means the Health Services Permit Agency;
- (2) "Category of services" or "health services" means "home health-care services" as defined by § 20-10-801;
- (3) "Commission" means the Health Services Permit Commission;
- (4) "Conversion of services" means an alteration of the category of services offered by a health facility;

(5) “Director” means the Director of the Health Services Permit Agency;

(6)(A) “Health facility” means “long-term care facility” as defined by § 20-10-101 or “home healthcare services agency” as defined by § 20-10-801.

(B) “Health facility” shall not mean and nothing in this subchapter shall be deemed to require a permit of approval for or to otherwise regulate in any manner the licensure of:

(i) A “hospital” as defined by and licensed pursuant to § 20-9-201, except when a hospital seeks to add long-term care beds or to convert acute beds to long-term care beds or to add home health services pursuant to a letter of intent filed with the Department of Health after February 15, 1993, or to expand home health services pursuant to a letter of intent filed with the Department of Health after February 15, 1993;

(ii) Offices of private physicians and surgeons;

(iii) Outpatient surgery or imaging centers;

(iv) Post-acute head injury retraining and residential care facilities or establishments operated by the United States Government or any agency thereof;

(v) Free-standing radiation therapy centers;

(vi) Expansion, not to exceed fifteen (15) beds, of the twenty-five-bed nonprofit intermediate care facility for individuals with developmental disabilities that provides transitional rehabilitation for pediatric patients;

(vii) Residences for four (4) or fewer individuals with developmental disabilities who receive support and services from nonprofit providers currently licensed by the Division of Developmental Disabilities Services of the Department of Human Services;

(viii) Any facility which is conducted by and for those who rely exclusively upon treatment by prayer for healing in accordance with the tenets or practices of any recognized religious denomination; or

(ix) Any bed or facility used to provide care to delinquent juveniles committed into the care of the Division of Youth Services.

(C) “Health facility” shall not include offices of private physicians and surgeons, outpatient surgery or imaging centers, establishments operated by the United States Government or any of its agencies, free-standing radiation therapy centers, or any facility which is conducted by and for those who rely exclusively upon treatment by prayer alone for healing in accordance with the tenets or practices of any recognized religious denomination; and

(7) “Transitional rehabilitation” means rehabilitation that typically results in discharge within twenty-four (24) months after the date of admission.

History. Acts 1987, No. 593, § 1; 1987 422, §§ 1, 2, 7; 1993, No. 472, § 1; 1997, (1st Ex. Sess.), No. 40, §§ 1, 2; 1989, No. No. 1025, § 1; 2001, No. 1583, § 2; 2001,

No. 1800, § 6.

20-8-102. Health Services Permit Commission — Creation — Members — Meetings.

- (a) There is established the Health Services Permit Commission.
- (b) The commission shall be composed of the following membership appointed by the Governor and confirmed by the Senate:
 - (1) A practicing physician;
 - (2) A representative of the Department of Human Services;
 - (3) A member of the Arkansas Hospital Association, Inc.;
 - (4) A member of the Arkansas Health Care Association;
 - (5) A member of the Arkansas chapter of AARP, Inc.;
 - (6) A member of the HomeCare Association of Arkansas;
 - (7) A consumer knowledgeable in business health insurance;
 - (8) A member of the Arkansas Residential Assisted Living Association, Inc.; and
 - (9) A member of the Hospice and Palliative Care Association of Arkansas, Inc.
- (c)(1) All appointments shall be for four-year terms.
- (2) No member shall be appointed to serve more than two (2) consecutive full terms.
- (d) The members shall serve without pay, but those members not employed by the State of Arkansas may receive expense reimbursement in accordance with § 25-16-901 et seq.
- (e) The commission shall meet at least quarterly and at such other times as necessary to carry out its duties under this subchapter. The commission shall elect one (1) of its members as chair, and by appropriate adoption of bylaws and rules, may provide for the time, place, and manner of calling its meetings.

History. Acts 1987, No. 593, § 2; 1987 § 1; 1997, No. 250, § 179; 2001, No. 632, (1st Ex. Sess.), No. 40, § 3; 1991, No. 623, § 1; 2001, No. 1800, § 7.

20-8-103. Health Services Permit Commission — Powers and duties.

- (a) The Health Services Permit Commission shall evaluate the availability and adequacy of health facilities and health services as they relate to long-term care facilities and home healthcare service agencies in this state.
- (b) The commission shall designate those locales or areas of the state in which, due to the requirements of the population or the geography of the area, the health service needs of the population are underserved.
- (c) The commission may specify, within locales or areas, categories of health services which are underserved or overserved due to the composition or requirements of the population or the geography of the area.
- (d) The commission shall develop policies and adopt criteria, including time limitations, to be utilized by the Health Services Permit

Agency in the review of applications and the issuing of permits of approval for a long-term care facility or a home healthcare service agency as provided in this subchapter.

(e) The commission may define certain underserved locales or areas or categories of services within underserved locales or areas to be exempt for specified periods of time from the permit-of-approval requirement.

(f) The commission may set application fees for permit-of-approval applications to be charged and collected by the agency.

(g)(1) Upon appeal by the applicant or an interested party, the commission shall conduct hearings on decisions by the agency within ninety (90) days of the agency decision. The commission shall render its final decision within fifteen (15) days of the close of the hearing. Failure of the commission to take final action within these time periods shall be considered a ratification of the agency decision and shall constitute the final decision of the commission from which an appeal to circuit court may be filed.

(2) Neither a competitor of a successful applicant for a permit of approval nor any other party shall have the right to appeal the commission's decision to grant a permit of approval.

History. Acts 1987, No. 593, § 3; 1987 (1st Ex. Sess.), No. 40, §§ 4, 5; 1989, No. 422, §§ 3-5; 2001, No. 1800, § 8.

CASE NOTES

ANALYSIS

Review.

—Agency Recommendation.

—Judicial.

Review.

—Agency Recommendation.

Under former subsection (f), the commission must review agency recommendations and either endorse or reject them, whether the agency makes a timely recommendation on an application, or fails to act under § 20-8-104(d), in which case the application is deemed approved because of the agency's inaction. *Riverways Home Care v. Ark. Health Servs. Comm'n*, 309 Ark. 452, 831 S.W.2d 611 (1992) (decision under prior law).

This chapter provides administrative procedural redress for review of the commission's approval of a permit to construct a nursing home facility, as is evident from the provisions of this section by which the General Assembly provided for the review of agency recommendations, which the

commission may endorse or reject; while subsection (g)(1) provides that the commission, upon appeal by the applicant, must conduct hearings on permits of approval by the agency, there is nothing in this language, or that in former subsection (f), that would prevent an applicant from requesting the review of the agency's recommendations or the approval of a permit. *Regional Care Facilities, Inc. v. Rose Care, Inc.*, 322 Ark. 780, 912 S.W.2d 406 (1995) (decision under prior law).

—Judicial.

Provided the commission follows its procedures and considers its own review criteria, the ultimate decision to grant a permit of approval is a discretionary one for the commission to make; the court will uphold the commission's exercise of its discretion in reaching this decision if it is supported by substantial evidence and is not arbitrary, capricious, or an abuse of its discretion. *Beverly Enterprises-Arkansas, Inc. v. Ark. Health Servs. Comm'n*, 308 Ark. 221, 824 S.W.2d 363 (1992).

To set aside the commission's action as

arbitrary and capricious, a party must prove that the action was a willful and unreasoning action, made without consideration and with a disregard of the facts or circumstances of the case. *Beverly Enterprises-Arkansas, Inc. v. Ark. Health Servs. Comm'n*, 308 Ark. 221, 824 S.W.2d 363 (1992).

Cited: *ABC Home Health of Ark., Inc. v. Ark. Health Servs. Comm'n*, 326 Ark. 573, 932 S.W.2d 331 (1996); *Ark. Residential Assisted Living Ass'n v. Ark. Health Servs. Permit Comm'n*, 364 Ark. 372, 220 S.W.3d 665 (2005).

20-8-104. Health Services Permit Agency — Powers and duties.

(a) There is created and established the Health Services Permit Agency, which shall be an independent agency under the supervision and control of the Governor.

(b) The agency shall possess and exercise such duties and powers as necessary to implement the policy and procedures adopted by the Health Services Permit Commission.

(c) The agency shall review all applications for permits of approval and approve or deny the application within ninety (90) days from the date the application is deemed complete and submitted for review.

(d) The State of Arkansas shall not participate in the capital expenditures review program, otherwise known as the 1122 Program, unless it becomes mandatory for continuation in federal programs authorized under Title V of the Social Security Act, 42 U.S.C. § 701 et seq., Title XIV of the Social Security Act, 42 U.S.C. § 1351 et seq., and Title XVII of the Social Security Act, 42 U.S.C. § 1391 et seq., for all states.

(e) The agency shall assist the commission in the performance of its duties under this subchapter.

History. Acts 1987, No. 593, § 4; 2001, No. 1800, § 9.

CASE NOTES

ANALYSIS

Review.

—Administrative.

—Judicial.

Review.

Permits of approval will only be issued, denied or withdrawn by the agency with the commission's endorsement or under the direction of an appropriate court. *Riverways Home Care v. Ark. Health Servs. Comm'n*, 309 Ark. 452, 831 S.W.2d 611 (1992) (decision under prior law).

—Administrative.

Under former § 20-8-103(f), the commission must review agency recommendations and either endorse or reject them, whether the agency makes a timely recommendation on an application, or fails to

act under subsection (d), in which case the application is deemed approved because of the agency's inaction. *Riverways Home Care v. Ark. Health Servs. Comm'n*, 309 Ark. 452, 831 S.W.2d 611 (1992) (decision under prior law).

—Judicial.

On review of agency decisions, the court determines whether an agency's interpretation of its regulations is reasonable and, although not binding on the court, an agency's interpretation of its own rules is persuasive. *Beverly Enterprises-Arkansas, Inc. v. Ark. Health Servs. Comm'n*, 308 Ark. 221, 824 S.W.2d 363 (1992).

Arkansas Health Services Commission's new rule that allowed the Commission to disregard the overall county occupancy requirement one time in order to approve a 70-bed nursing home facility in

a single county where the projected need for the county exceeded the “existing” beds by 250 or more beds was not arbitrary special or local legislation because it was conceivable that other counties in the state would, in the future, come under the rule’s provisions. Ark. Health Servs.

Comm’n v. Reg’l Care Facilities, Inc., 351 Ark. 331, 93 S.W.3d 672 (2002).

Cited: Ark. Health Servs. Comm’n v. Area Agency on Aging, 303 Ark. 38, 792 S.W.2d 321 (1990); ABC Home Health of Ark., Inc. v. Ark. Health Servs. Comm’n, 326 Ark. 573, 932 S.W.2d 331 (1996).

20-8-105. Director.

There shall be a Director of the Health Services Permit Agency, who shall be the executive head of the Health Services Permit Agency. The director shall be appointed by the Governor, subject to confirmation by the Senate, and shall serve at the pleasure of the Governor.

History. Acts 1987, No. 593, § 5; 2001, No. 1800, § 10.

20-8-106. Health Services Program — Permits generally.

(a)(1) A permit of approval shall not be required by the Health Services Permit Agency or the Health Services Permit Commission for any applicant to qualify for a Class B license, as provided in § 20-10-801 et seq., to operate a home healthcare services agency, if the home healthcare services agency was serving patients on or before June 30, 1988, and if the home healthcare services agency serves the residents of the county where the principal office is located.

(2) Nursing home applications under review by the Health Services Permit Agency on June 2, 1987, are considered under the provisions of this subchapter under updated standards on a county-by-county basis.

(3)(A) Beginning July 1, 2005, the Health Services Permit Agency may not accept applications for permits of approval for the construction of new residential care facilities.

(B) Applications for replacement of residential care facilities may not be accepted and processed after July 1, 2005.

(C) However, applications for replacement of residential care facilities shall be accepted for residential care facilities of sixteen (16) beds or fewer but only if the number of beds required for replacement is less than or equal to the number of beds for which the residential care facility was licensed before the application for replacement.

(b)(1)(A) The alteration or renovation of a health facility having an associated capital expenditure of less than one million dollars (\$1,000,000) for nursing homes and not resulting in additional bed capacity shall not require a permit of approval.

(B) However, the Health Services Permit Agency shall not allow hospital acute care beds to be converted to or allow their license classification to be changed to long-term care beds without going through the permit-of-approval process.

(2) Permits, legal title, and right of ownership may be transferred with the approval of the commission if the entity presently holding the permit, legal title, or right of ownership has tangible assets of at least

two thousand five hundred dollars (\$2,500) that will be transferred with the permit, legal title, or right of ownership.

(3) The application for the permit of approval shall include, but need not be limited to, such information as is necessary to determine:

(A) Whether the proposed project is needed or projected as being necessary to meet the needs of the locale or area in terms of the health care required for the population or geographic region;

(B) Whether the proposed project can be adequately staffed and operated when completed;

(C) Whether the proposed project is economically feasible; and

(D) Whether the project will foster cost containment through improved efficiency and productivity.

(c) If the application is granted, the Health Services Permit Agency shall issue a permit of approval, if it finds that the proposed project meets the criteria for approval as set by the commission. If the application is denied, the Health Services Permit Agency shall send written notice of the denial to the applicant which sets forth the criteria that the proposed project failed to meet.

(d) Any applicant or interested party seeking review of a final Health Services Permit Agency decision regarding permits of approval, movement of beds, or transfer of permits of approval shall file a written appeal for hearing before the commission on an approved form within thirty (30) days of the receipt of the Health Services Permit Agency decision.

(e) Appeals to the commission shall be conducted in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

History. Acts 1987, No. 593, § 6; 1987 (1st Ex. Sess.), No. 40, § 6; 1989, No. 422, § 6; 1989, No. 533, § 1; 2001, No. 1800, § 11; 2005, No. 1669, § 1; 2009, No. 649, § 1; 2013, No. 1132, § 2.

A.C.R.C. Notes. Acts 1987 (1st Ex. Sess.), No. 40, § 8, provided: "Any hospital licensed by the Arkansas State Department of Health that applied to operate a home health agency under the provisions of Act 593 of 1987 before June 1, 1987, shall be exempt from the permit of approval requirement. Any agency, firm, corporation or organization that applied to operate a home health agency under the provisions of Act 593 of 1987 before June 1, 1987 must reapply to the Health Services Agency no later than June 30, 1987 to be reviewed and exempt from the moratorium contained in Section 6 of Act 593 of 1987 as amended herein."

torium contained in Section 6 of Act 593 of 1987 as amended herein."

Acts 1987 (1st Ex. Sess.), No. 40, § 9, provided: "Any hospital desiring to operate a home health agency which is located in a municipality with a population of more than 10,000 but less than 11,000 in a county with a population of 26,000 or more according to the 1980 Federal decennial census, shall be exempt from the permit of approval requirement and the moratorium contained in Section 6 of Act 593 of 1987 as amended herein."

Amendments. The 2013 amendment deleted (a)(1) and redesignated former (a)(2) through (a)(4) as present (a)(1) through (a)(3); in present (a)(1), substituted "A" for "No" and inserted "not"; and substituted "are" for "shall be" in (a)(2).

CASE NOTES

ANALYSIS

Construction.
 Applicability.
 Economic Feasibility.
 Evidence.
 Geographic Region.
 Issuance Improper.

Construction.

This chapter provides administrative procedural redress for review of the commission's approval of a permit to construct a nursing home facility, as is evident from the provisions of § 20-8-103 by which the General Assembly provided for the review of agency recommendations, which the commission may endorse or reject; while former § 20-8-103(h) provided that the commission, upon appeal by the applicant, must conduct hearings on permits of approval by the agency, there is nothing in this language, or in former § 20-8-103(f), that would prevent an applicant from requesting the review of the agency's recommendations or the approval of a permit. *Regional Care Facilities, Inc. v. Rose Care, Inc.*, 322 Ark. 780, 912 S.W.2d 406 (1995) (decision under prior law).

Applicability.

Act 40 of 1987 does not apply only to the review and issuance of permits of approval; it is applicable to the licensure of projects, as the clear language of the act states, "nor shall there be any additional beds licensed for ... nursing homes ... in this state." *Ark. Dep't of Human Servs. v. Greene Acres Nursing Homes, Inc.*, 296 Ark. 475, 757 S.W.2d 563 (1988).

Where nursing home submitted its application to add beds to its facilities during the effective dates of Act 593 of 1987, it qualified for the exception to the permit of approval requirement, however, although its application for a license was complete under Act 593 of 1987 for purposes of processing and review, a license for that application still had not been granted prior to the effective date of Act 40 of 1987, and the clear language of Act 40 of 1987 prohibited the issuance of a license during the effective dates of the moratorium; the fact that Act 40 of 1987 resulted in the denial of licenses with respect to applications submitted prior to its enactment

does not mean that it is being applied retroactively but, rather, Act 40 of 1987 is being applied from and after its effective date of June 19, 1987, to impose the legislatively mandated moratorium. *Ark. Dep't of Human Servs. v. Greene Acres Nursing Homes, Inc.*, 296 Ark. 475, 757 S.W.2d 563 (1988).

Economic Feasibility.

The commission is not required to find a guarantee of success before it grants a permit, but rather to consider an applicant's relative chances for economic success, including approved financing and expressed local support. *Beverly Enterprises-Arkansas, Inc. v. Ark. Health Servs. Comm'n*, 308 Ark. 221, 824 S.W.2d 363 (1992).

Evidence.

Evidence insufficient to support issuance of a certificate of need. *Statewide Health Coordinating Council v. General Hosps. of Humana, Inc.*, 280 Ark. 443, 660 S.W.2d 906 (1983), cert. denied, 467 U.S. 1205, 104 S. Ct. 2386, 81 L. Ed. 2d 344 (1984) (decision under prior law).

Evidence sufficient to support grant of permit. *Beverly Enterprises-Arkansas, Inc. v. Ark. Health Servs. Comm'n*, 308 Ark. 221, 824 S.W.2d 363 (1992).

Agency's methodology in calculating occupancy rate and economic feasibility was upheld; consequently, its finding that the proposed project did not meet the requirements of subsection (b) of this section was also upheld. *Ark. Health Servs. Agency v. Desiderata, Inc.*, 331 Ark. 144, 958 S.W.2d 7 (1998).

Geographic Region.

The commission's action in limiting its consideration of the criteria of need to within county limits was a reasonable action made in consideration of its policies and procedures; this action was not arbitrary or capricious and was consistent with the legislature's mandate. *Beverly Enterprises-Arkansas, Inc. v. Ark. Health Servs. Comm'n*, 308 Ark. 221, 824 S.W.2d 363 (1992).

Issuance Improper.

Agency was not authorized to issue a certificate of need where none of the exceptional circumstances specified in the

laws and regulations were shown. State-wide Health Coordinating Council v. General Hosps. of Humana, Inc., 280 Ark. 443, 660 S.W.2d 906 (1983), cert. denied, 467 U.S. 1205, 104 S. Ct. 2386, 81 L. Ed. 2d 344 (1984) (decision under prior law).

Cited: Ark. Dep't of Human Servs. v. M.D.M. Corp., 295 Ark. 549, 750 S.W.2d 57 (1988).

20-8-107. Expansion of facilities or services.

(a) Unless otherwise provided in this subchapter, all health facilities seeking to add new beds or home health services or to expand existing bed capacity or home health services shall apply for a permit approving additional beds or services or expanded bed capacity or services pursuant to procedures and criteria promulgated by the Health Services Permit Commission.

(b) The commission may authorize the Health Services Permit Agency to enjoin construction or expansion of existing facilities of any project commenced in violation of this subchapter through an action filed in the circuit court of the judicial district in which the project is located.

(c) In no event shall the requirements of this subchapter apply to any facility licensed or approved as of March 1, 2003, by the Child Welfare Agency Review Board pursuant to the Child Welfare Agency Licensing Act, § 9-28-401 et seq., and as specifically exempted by § 9-28-407(a)(3).

(d) Beginning July 1, 2005, the Health Services Permit Agency may not accept applications or requests for permits of approval to add new beds or to expand existing bed capacity of residential care facilities.

History. Acts 1987, No. 593, § 7; 1987 (1st Ex. Sess.), No. 40, § 7; 2003, No. 1285, § 2; 2005, No. 1669, § 2.

20-8-108. Fees and fines.

All fees and fines collected under this subchapter shall be deposited into the Miscellaneous Agencies Fund Account to be used exclusively for the maintenance and operation of the Health Services Permit Agency.

History. Acts 1987, No. 593, § 8; 1987 (1st Ex. Sess.), No. 40, § 10; 2001, No. 1800, § 12.

20-8-109. Approval of new projects — Repeal of Acts 1975, No. 558, § 5 — Transfer of duties — Definition.

(a) All projects requiring approval under the Certificate of Need Program as established by Acts 1975, No. 558, § 5 [repealed], except freestanding radiation therapy centers, shall not be instituted or commenced after April 4, 1987, except upon application for and receipt of approval from the Health Services Permit Agency utilizing the same criteria and procedures in existence before April 4, 1987.

(b) As used in this section, “commence construction” means the approval of project financing or the actual movement onto the site of building materials and equipment by the principal contractor.

(c) Two hundred ten (210) days after April 4, 1987, Acts 1975, No. 558, § 5, as amended, is repealed. On and after the two hundred eleventh day following April 4, 1987, all projects requiring approval under § 20-8-107 shall not be instituted or commenced except upon application for and receipt of a permit of approval as set forth in this subchapter, and, during this period of time, all duties and responsibilities of the State Health Planning and Development Agency and the Statewide Health Coordinating Council are transferred to the Health Services Permit Agency established under this subchapter. Any project not requiring approval under this subchapter, even though covered under Acts 1975, No. 558, § 5 [repealed], may be commenced after April 4, 1987.

(d) The Health Services Permit Agency shall process all applications or certificates of need for intermediate care facilities for the individuals with developmental disabilities with fifteen (15) or fewer beds which were pending on April 4, 1987, and shall for a period of thirty (30) days after April 4, 1987, accept additional applications for such facilities. The applications shall be processed utilizing the criteria and procedures in existence before April 4, 1987, and in addition the Health Services Permit Agency shall consider as a primary factor the experience of each applicant in serving the developmentally disabled population.

History. Acts 1987, No. 593, § 9; 1987 (1st Ex. Sess.), No. 40, § 11; 2001, No. 1800, § 13.

CASE NOTES

Cited: Ark. Residential Assisted Living Comm’n, 364 Ark. 372, 220 S.W.3d 665 Ass’n v. Ark. Health Servs. Permit (2005).

20-8-110. Collection and dissemination of health data.

(a) The Health Services Permit Agency shall act as a statewide health data clearinghouse for the acquisition and dissemination of data from healthcare providers, the Arkansas Medicaid Program, third-party payors, state agencies, and other appropriate sources in furtherance of this section.

(b) All state agencies having information with regard to health matters shall make available to the Health Services Permit Agency such health data as is necessary for the Health Services Permit Commission to carry out its responsibilities.

(c) All health facilities requiring a permit of approval by the state shall submit annually a report of utilization statistics as may be required by the Health Services Permit Agency.

(d) The Insurance Commissioner shall require all third-party payors, including, but not limited to, licensed insurers, medical and hospital

service corporations, health maintenance organizations, and self-funded employee health plans, to provide the commission with claims data for health matters.

(e) State agencies which survey hospitals, home health agencies, outpatient surgery centers, or nursing homes for licensure or certification shall annually report to the Health Services Permit Agency on the surveys of the various facilities. The annual report shall list facilities by name with patient care citations and numbers of serious patient injuries per year by facility.

(f) The Director of the Health Services Permit Agency shall be empowered to release data collected pursuant to this section, subject to the following limitations:

(1) Data released shall not include any information which could be used to identify any individual patient; and

(2) Data released shall not include any information which could be used to associate any of the data with any specific third-party payor.

(g) The director shall prescribe such rules and regulations as may be necessary to carry out the purpose of this section.

(h)(1) With the advice of the commission, the director shall compile and publish summaries of health data collected by the Health Services Permit Agency.

(2)(A) The director shall prepare an annual report of the Health Services Permit Agency's findings and submit the report to the Governor, the General Assembly, and the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor or appropriate subcommittees thereof.

(B) The Health Services Permit Agency shall provide assistance to the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor in the development of information necessary in the examination of health-care issues.

(i)(1) The Health Services Permit Agency may impose a fine on health facilities requiring a permit of approval for failure to timely submit reports of statistics as required by the Health Services Permit Agency.

(2) The Health Services Permit Agency may impose a fine of:

(A) Up to one hundred dollars (\$100) for a report more than thirty (30) days late;

(B) Two hundred fifty dollars (\$250) for a report more than sixty (60) days late; and

(C) Five hundred dollars (\$500) for a report more than ninety (90) days late.

History. Acts 1989, No. 107, §§ 1-4; 1997, No. 179, § 23; 2001, No. 1800, § 14; 2005, No. 1271, §§ 1, 2; 2007, No. 827, § 149; 2007, No. 1589, §§ 1, 2.

A.C.R.C. Notes. Pursuant to Acts 2007,

No. 827, § 240, the amendment of § 20-8-110 by Acts 2007, No. 1589, § 2 supercedes the amendment of § 20-8-110 by Acts 2007, No. 827, § 149.

20-8-111. Transfer of Developmental Disabilities Planning Council attributes to other agency.

The Governor may at any time transfer all personnel, appropriations, fund balances, and authorized positions, and the powers, duties, and personnel of the Developmental Disabilities Planning Council to any other designated agency of the state which meets the requirements of Pub. L. No. 101-496 [repealed].

History. Acts 1993, No. 821, § 6.

A.C.R.C. Notes. References to “this subchapter” in §§ 20-8-101 — 20-8-110 may not apply to this section, which was enacted subsequently.

This section may be superseded by § 20-8-112.

U.S. Code. Pub. L. No. 101-496, referred to in this section and codified as 42 U.S.C. § 6000 et seq., was repealed by Pub. L. No. 106-402 on October 30, 2000. For similar provisions, see 42 U.S.C. §§ 15001, 15002.

20-8-112. Additional transfer of Developmental Disabilities Planning Council attributes to other agency.

The Governor may at any time transfer all the powers, duties, personnel, appropriations, fund balances, and authorized positions of the Developmental Disabilities Planning Council to any other designated agency of the state which meets the requirements of Pub. L. No. 103-230 [repealed].

History. Acts 1995, No. 77, § 6; 1997, No. 58, § 8.

A.C.R.C. Notes. References to “this subchapter” in §§ 20-8-101 — 20-8-110 may not apply to this section which was enacted subsequently.

U.S. Code. Pub. L. No. 103-230, referred to in this section and codified as 42 U.S.C. § 6001 et seq., was repealed by Pub. L. No. 106-402 on October 30, 2000. For similar provisions, see 42 U.S.C. §§ 15001, 15002.

20-8-113. Findings.

The General Assembly finds and determines that:

(1) The Division of Youth Services of the Department of Human Services is obligated by law to provide appropriate care to juveniles adjudicated delinquent and committed to the division’s custody;

(2) The division, pursuant to judicial decrees, assumes custody of delinquent juveniles with little or no notice;

(3) The nature of the criminal conduct engaged in by the juvenile may create the necessity to segregate these juveniles within treatment facilities, thereby denying the division otherwise available beds;

(4) The division must secure sufficient facilities for the care of delinquent juveniles in its custody;

(5) The need for these facilities may vary substantially from the needs anticipated by the Department of Human Services or by the Health Services Permit Commission; and

(6) No permit of approval should be required for facilities or beds contracted for or otherwise provided for delinquent youth committed to the custody of the division or the beds provided for delinquent youth

counted against the authorized beds otherwise provided by a facility or organization with a permit of approval.

History. Acts 2001, No. 1583, § 1.

SUBCHAPTER 2 — ARKANSAS SPINAL CORD COMMISSION

SECTION.

20-8-201. Legislative intent.
20-8-202. Creation — Members.
20-8-203. Powers and duties.
20-8-204. [Repealed.]

SECTION.

20-8-205. [Repealed.]
20-8-206. Central registry — Definition
— Legislative intent.

Effective Dates. Acts 1975, No. 311, § 9: Mar. 4, 1975. Emergency clause provided: "It is hereby found and determined by the General Assembly that legislative findings and purposes set forth in Section 1 of this Act document the immediate need for the establishment of an adequate program to assist in the treatment and rehabilitation of persons suffering from congenital and acquired spinal cord dysfunctions, and that the immediate passage of this Act is necessary to enable the Governor to establish a State Spinal Cord Commission to immediately commence the development, implementation, and operation of a spinal cord treatment program in this State for deserving and qualified citizens of this State. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the immediate preservation of the public peace, health, and safety, shall be in full force and effect from and after the date of its passage and approval."

Acts 1977, No. 428, § 2: passed over Governor's veto, Mar. 15, 1977. Emergency clause provided: "It is hereby found and determined by the General Assembly that the State Spinal Cord Commission performs vital services benefiting spinal cord injured victims in this State; that the immediate reorganization of the said Commission is necessary to provide for a

more efficient Commission, and that the immediate passage of this Act is necessary to accomplish such purpose. Therefore, an emergency is hereby declared to exist and this Act, being necessary for the immediate preservation of the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Acts 1997, No. 250, § 258: Feb. 24, 1997. Emergency clause provided: "It is hereby found and determined by the General Assembly that Act 1211 of 1995 established the procedure for all state boards and commissions to follow regarding reimbursement of expenses and stipends for board members; that this act amends various sections of the Arkansas Code which are in conflict with the Act 1211 of 1995; and that until this cleanup act becomes effective conflicting laws will exist. Therefore an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

20-8-201. Legislative intent.

(a) It is declared and found that a major problem facing medicine and the public health and welfare is the absence of an adequate program to

assist in the treatment and rehabilitation of persons suffering from congenital or acquired spinal cord dysfunction.

(b)(1) It has been found that no fewer than one thousand one hundred (1,100) Arkansas residents presently suffer from spinal cord injury or damage, and it is estimated that at least one hundred twenty (120) Arkansans experience serious injury or congenital dysfunction of the spinal cord annually.

(2) Furthermore, it has been found that a fully coordinated approach to the early recognition, the emergency care and transportation, the definitive treatment and rehabilitation, and the long-term management direction and support of such persons is presently lacking and yet is essential to guaranteeing these patients the best possible opportunity to minimize mortality, morbidity, and permanent disability.

(3) It is further recognized that the enormous cost for medical services, hospitalization, and rehabilitative care of spinal cord injured persons makes it extremely difficult, and often financially impossible, for persons of moderate or modest means to secure adequate medical and rehabilitative services, and in most cases, services are financially possible only by the very wealthy, if at all.

(4) Therefore, to guarantee the best possible opportunity for minimizing the mortality, morbidity, and permanent disability of persons due to spinal cord injury or dysfunction, it is essential that the state develop a program to:

(A) Provide for complete identification and visible integration of the numerous complex funding mechanisms which are applicable to the needs of a particular individual at each overlapping stage of treatment and rehabilitation and provide financial assistance when necessary to fill a specific identified gap in funding a portion of the coordinated treatment and rehabilitation plan of a specified patient when the patient's own financial resources are insufficient to meet such requirements;

(B) Authorize the development and operation of an Arkansas spinal cord treatment center and system which will integrate present treatment and rehabilitative capabilities and develop additional service capabilities as necessary to guarantee the availability of continuously current and evolving new processes in state-of-the-art treatment and rehabilitative services to all spinal cord disabled Arkansans; and

(C) Provide for full coordination of treatment and rehabilitation efforts from problem recognition through progressive rehabilitation and for as long as a need for these specialized services shall exist.

History. Acts 1975, No. 311, § 1; A.S.A. 1947, § 82-3301.

20-8-202. Creation — Members.

(a) There is established the Arkansas Spinal Cord Commission, to consist of five (5) members to be appointed by the Governor from the state at large for terms of ten (10) years and confirmed by the Senate, as provided by law. The members of the commission shall be either spinal cord injured victims themselves, members of the immediate families of spinal cord injured victims, or persons with special knowledge of and experience with spinal cord injuries and dysfunctions who have demonstrated active involvement and interest in the fight against death and disability due to spinal cord injury and dysfunction.

(b) Members of the commission shall serve until their successors are appointed and confirmed.

(c) If a vacancy occurs on the commission due to death, resignation, or other cause, the vacancy shall be filled by appointment of the Governor of a person eligible for the initial appointment as set forth in this section, to serve for the remainder of the unexpired portion of the term of the member.

(d)(1) The commission shall select a disbursing officer of funds appropriated to the commission. All expenditures shall be approved by the chair of the commission before their disbursement.

(2) The commission shall annually elect one (1) of its members as chair and one (1) of its members as vice chair, and other officers as the commission deems necessary.

(e) Members of the commission shall serve without pay but shall be reimbursed from commission funds, if available, for reasonable and necessary expenses incurred in attending to commission business, in the same manner and in accordance with the same conditions, restrictions, and limitations as are applicable to employees of the state.

(f) Members of the commission shall qualify by taking the oath of office as prescribed by law.

(g) The commission shall meet at least one (1) time each calendar quarter and at such other times as may be designated by the commission's rules, or upon call by the chair or by the written request of any four (4) members.

(h)(1) From time to time, the commission may create advisory committees as are deemed necessary to assist the commission in formulating policies, effectuating and reviewing operating procedures, and for such other purposes as the commission may deem appropriate.

(2) The members of the advisory committees shall serve without pay, but the commission may reimburse members of the advisory committees for expenses in accordance with § 25-16-901 et seq. if sufficient funds are available.

History. Acts 1975, No. 311, §§ 2, 3; 3302, 82-3303; Acts 1987, No. 263, §§ 1, 2; 1977, No. 428, § 1; A.S.A. 1947, §§ 82- 1993, No. 1154, § 1; 1997, No. 250, § 180.

20-8-203. Powers and duties.

The Arkansas Spinal Cord Commission shall have the following functions, powers, and duties:

(1) To identify and cooperate with existing agencies, organizations, and individuals offering services to the spinal cord injured or spina bifida patient for the establishment and integration of a statewide system of treatment, rehabilitation, counseling, and social services by means of entering into cooperative agreement with the agencies, organizations, and individuals. The programs shall be designed and administered to:

(A) Provide for coordinated and integrated development and continued review of a full treatment and rehabilitation plan for each qualified applicant patient;

(B) Identify all possible and existing funding sources for each type of service identified in the treatment plan for which a qualified patient may be eligible and assist the patient in obtaining funding assistance for which he or she is eligible from existing sources;

(C) Assess the patient's financial ability to pay for needed services identified in the treatment plan for which no other funding sources are available;

(D) Provide financial assistance for persons unable to pay for the services, including special equipment, without causing unjust and unusual hardship, including, but not limited to, a drastic lowering of the standard of living to the person or his or her immediate family;

(E) Identify service needs which cannot be adequately met by existing resources;

(F) Provide for increased accountability by documenting the full range of fiscal resources being invested from the various funding sources toward the achievement of each patient's service plan objectives; and

(G) Provide an annual report to the Governor, to the General Assembly, and to the public documenting areas of success, unresolved problems, and overall cost-benefit analyses of expenditures from the various sources;

(2)(A) To develop or cause to be developed an Arkansas spinal cord treatment center and system to serve the entire state through the provision of such direct and indirect services as may be identified and documented as provided in subdivision (1) of this section.

(B) The center and system may provide such services as:

(i) Specialized emergency and acute care;

(ii) Specialized emergency transfer services;

(iii) Specialized diagnostic and prescriptive services;

(iv) Specialized rehabilitative services;

(v) Family education and home care outreach services;

(vi) Coordinated services;

(vii) Continuing educational services for physicians and other health professionals and paraprofessionals who deal with the spinal cord patient; and

(viii) Other services deemed necessary and appropriate by the commission.

(C) At such time as an Arkansas spinal cord treatment center is established, the commission shall serve as its board of directors and may either directly administer the operation of the center or may enter into contractual agreements with existing institutions for facilities, staffing, and administrative services or such other services as the commission deems appropriate.

(D)(i) Until an Arkansas spinal cord treatment center is established, or after a center is established, the commission may contract and pay for services provided by other institutions whenever the commission determines it to be in the best interest of a spinal cord injured person.

(ii) It is the intent of this subchapter that the commission have broad discretion in providing or obtaining for spinal cord injured patients a complete level of services which the commission deems to be in the best interest of the patient, as set forth in this subchapter;

(3) To work with all appropriate agencies, organizations, and individuals throughout the state to develop a fully integrated statewide network of coordinated services for spinal cord patients covering all needed services from the detection of spinal cord injuries or congenital conditions through the related phases of emergency care and transfer, acute and definitive care, and rehabilitative and follow-up care and to thus effect a measured reduction in spinal cord-related morbidity and mortality, long-term disability, and long-term maintenance system expenditures of public funds;

(4) To provide special expert consultation and services to cooperating and participating agencies, institutions, and individuals, including appropriate elements of the emergency medical services system, on the emergency care and transportation of spinal cord injured persons as well as to other agencies, institutions, and individuals responsible for the delivery of professional medical and health sciences education and training necessary for providing appropriate progressive and evolving specialized programs of treatment of service to spinal cord injured and spina bifida patients;

(5) To develop standards for determining eligibility for assistance to defray the cost of care and treatment of spinal cord patients under this program; and

(6) To accept gifts, grants, and donations from private sources, from municipal and county governments, from the state, and from the United States Government to be used for the purposes of this subchapter to defray costs incurred by persons suffering from spinal cord disability who are unable to meet the total cost of treatment and rehabilitation and to promote the development of specialized service capability found to be needed but not available.

20-8-204. [Repealed.]

Publisher's Notes. This section, concerning the Fiscal Resource Advisory Committee, was repealed by Acts 1999,

No. 1133, § 2. The section was derived from Acts 1975, No. 311, § 5; A.S.A. 1947, § 82-3305.

20-8-205. [Repealed.]

Publisher's Notes. This section, concerning disbursement of funds, was repealed by Acts 1987, No. 263, § 3. The

section was derived from Acts 1975, No. 311, § 6; A.S.A. 1947, § 82-3306.

20-8-206. Central registry — Definition — Legislative intent.

(a)(1) The Arkansas Spinal Cord Commission shall establish and maintain a central registry of spinal cord disabled persons. Every public and private health and social agency and attending physician shall report to the commission within five (5) calendar days after identification of any spinal cord disabled person. However, the consent of the individual shall be obtained before making this report, except that every spinal cord disease or injury resulting in permanent partial, permanent total, or total disability shall be reported to the commission immediately upon identification.

(2) The report shall contain the name, age, residence, and type of disability of the individual and such additional information as may be deemed necessary by the commission.

(b)(1) Within fifteen (15) days of the report and identification of a spinal cord disabled person, the commission shall notify the spinal cord disabled person or the most immediate family members of their right to assistance from the state, the services available, and the eligibility requirements.

(2) The commission shall refer severely disabled persons to appropriate divisions, departments, and other state agencies to assure that maximum available rehabilitative services, if desired, are obtained by the spinal cord disabled person.

(3) All other agencies of the state shall cooperate with the commission to ensure that appropriate total rehabilitative and other services are available, as well as access to records and other information.

(c) As used in this section, "spinal cord disabled" means any person who has a spinal cord disease or injury, congenital or acquired, which results in partial or total loss of motor or sensory functions and which results in temporary or permanent partial or total disability.

(d) It is the intent of the General Assembly to ensure the referral of all spinal cord disabled persons to the commission by appropriate individuals or public and private agencies in order that all spinal cord disabled persons might obtain the appropriate total rehabilitative services rendered by existing state agencies, state departments, and other organizations and individuals.

History. Acts 1977, No. 170, §§ 1-4; 1977, No. 330, §§ 1-4; A.S.A. 1947, §§ 82-3307 — 82-3310; Acts 1993, No. 1154, § 2.

SUBCHAPTER 3 — GREAT STRIDES GRANT PROGRAM

SECTION.

20-8-301. Findings.

20-8-302. Use of funds — Regulations.

Publisher's Notes. Former subchapter 3 was repealed by Acts 1991, No. 343, § 8. The subchapter was derived from the following sources:

20-8-301. Acts 1979, No. 246, § 1; 1979, No. 679, § 1; A.S.A. 1947, § 82-4101.

20-8-302. Acts 1979, No. 246, §§ 2, 3; 1979, No. 679, §§ 2, 3; 1983, No. 131, §§ 1-3, 5; 1983, No. 135, §§ 1-3, 5; A.S.A. 1947, §§ 6-623 — 6-626, 82-4102, 82-4103.

20-8-303. Acts 1979, No. 246, §§ 4, 6; 1979, No. 679, §§ 4, 6; A.S.A. 1947, §§ 82-4104, 82-4106.

20-8-304. Acts 1979, No. 246, § 5; 1979, No. 679, § 5; A.S.A. 1947, § 82-4105.

20-8-305. Acts 1979, No. 246, § 6; 1979, No. 679, § 6; A.S.A. 1947, § 82-4106.

Acts 1991, No. 343, § 8, provided: "The Home Health Coordinating Council created under Arkansas Code § 20-8-302 is abolished."

20-8-301. Findings.

The General Assembly finds:

(1) That Arkansas consistently ranks among the most unhealthy states in the nation;

(2) That after just one (1) year of regular walking exercise, previously sedentary smokers refrained from smoking at two (2) times the rate of those who received only health education;

(3) That Arkansans who exercise regularly choose walking as their overwhelmingly preferred form of activity;

(4) That women who walk briskly or exercise vigorously may reduce their chances for heart disease by as much as forty percent (40%);

(5) That more than thirty-five percent (35%) of Arkansans do not exercise, placing Arkansas as the sixth most sedentary state in the nation;

(6) That, while people are inactive in all parts of the state, a greater percentage of the population in rural areas is inactive; and

(7) That a reduction in illnesses related to physical inactivity would save Arkansas millions of dollars each year in reduced healthcare costs.

History. Acts 2001, No. 1750, § 1.

20-8-302. Use of funds — Regulations.

(a) The Department of Health shall use funds from the Tobacco Settlement Proceeds Act, § 19-12-101 et seq., to establish the Great Strides Grant Program.

(b)(1) The department shall promulgate regulations to create a grant program which will allow local communities to participate in the Great Strides Grant Program.

(2) The department shall give priority in meeting the goals of this subchapter to grant proposals from rural communities.

History. Acts 2001, No. 1750, § 2.

SUBCHAPTER 4 — HEALTH DATA INITIATIVE

SECTION.

20-8-401. Legislative findings.

20-8-402. Program creation and administration.

SECTION.

20-8-403. Data access.

20-8-404. Rules.

20-8-401. Legislative findings.

The General Assembly finds and determines that there is a lack of Arkansas-specific information and data to guide officials responsible for policy decisions and that making this data readily available to decision makers is essential to the creation of effective health policy for the state.

History. Acts 2003, No. 1035, § 1.

20-8-402. Program creation and administration.

(a)(1) The Director of the Arkansas Center for Health Improvement shall establish and maintain a program to access health data to be known as the “Arkansas Health Data Initiative”.

(2) The initiative shall be administered and maintained within the the Arkansas Center for Health Improvement.

(b) The purpose of the initiative is to serve as an access point for studies concerning state and federal health information and to inform and support Arkansas health policy officials.

(c) Policy development and access to data under the initiative is contingent upon the availability of funding to support projects under the initiative.

History. Acts 2003, No. 1035, § 2.

20-8-403. Data access.

(a) If agreed to by state agencies responsible for maintaining requested data sources, the Arkansas Center for Health Improvement may have access to the agencies’ information and data to facilitate operation of the Arkansas Health Data Initiative.

(b) Data under subsection (a) of this section include:

- (1) Public health databases;
- (2) Healthcare-utilization data;

- (3) Financial data related to the procurement of health or health-care-related services;
- (4) Data supplied as part of mandated reporting requirements to state agencies by entities, including, but not limited to, other state agencies and departments, nonstate entities, external vendors, and other entities as identified by the initiative;
- (5) Data collected and maintained under the State Health Data Clearinghouse Act, § 20-7-301 et seq.; and
- (6) Other data sources supported and maintained with state funds.

History. Acts 2003, No. 1035, § 3.

20-8-404. Rules.

The Department of Information Systems, Department of Finance and Administration, Department of Health, Department of Human Services, State Insurance Department, and all other appropriate departments, agencies, subcontractors, and officers shall promulgate rules to implement this subchapter.

History. Acts 2003, No. 1035, § 4.

SUBCHAPTER 5 — NEWBORN UMBILICAL CORD BLOOD INITIATIVE ACT

SECTION.

- 20-8-501. Title.
- 20-8-502. Legislative findings.
- 20-8-503. Definitions.
- 20-8-504. Newborn Umbilical Cord Blood Initiative.
- 20-8-505. Arkansas Commission for the Newborn Umbilical Cord

SECTION.

- Blood Initiative — Creation — Members.
- 20-8-506. Arkansas Commission for the Newborn Umbilical Cord Blood Initiative — Powers and duties.

A.C.R.C. Notes. The Newborn Umbilical Cord Blood Bank established by this subchapter is also called the Cord Blood Bank of Arkansas.

Effective Dates. Identical Acts 2016 (3rd Ex. Sess.), Nos. 2 and 3, § 129: May 23, 2016. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act revises the membership and duties of certain agencies, task forces, committees, and commissions and repeals other governmental entities; that these revisions and repeals of governmental entities impact the expenses and operations of state government; and that the provi-

sions of this act should become effective as soon as possible to allow for implementation of the new provisions in advance of the upcoming fiscal year. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

20-8-501. Title.

This subchapter shall be known and may be cited as the “Newborn Umbilical Cord Blood Initiative Act”.

History. Acts 2007, No. 695, § 1.

RESEARCH REFERENCES

Ark. L. Rev. Comment, Tiny Wonders, the Stem Cell Phenomenon, 61 Ark. L. Huge Possibility: Arkansas Act 695 and Rev. 673.

20-8-502. Legislative findings.

The General Assembly finds that:

(1) More than one hundred million (100,000,000) Americans and two billion (2,000,000,000) other humans worldwide suffer from diseases that may eventually be treated more effectively or even cured with stem cells;

(2) Stem cell research has been hampered by the controversy over the use of embryonic stem cells;

(3) Stem cells are not found only in embryos;

(4) The umbilical cord, placenta, and amniotic fluid are rich in stem cells that may be used for scientific research and medical treatment without destroying embryos;

(5) Stem cell research using stem cells from postnatal tissue and fluid has already resulted in treatments for anemia, leukemia, lymphoma, lupus, multiple sclerosis, rheumatoid arthritis, sickle cell disease, spinal cord injury, and Crohn’s disease;

(6) Stem cell therapies using stem cells from postnatal tissue and fluid are being studied for diseases as wide-ranging and diverse as corneal degeneration, heart disease, stroke, Parkinson’s disease, and Alzheimer’s disease;

(7) It is the public policy of this state to encourage the donation, collection, and storage of stem cells collected from postnatal tissue and fluid and to make such stem cells available for both scientific research and medical treatment; and

(8) It is the public policy of this state to encourage ethical research in life science and regenerative medicine.

History. Acts 2007, No. 695, § 1.

20-8-503. Definitions.

As used in this subchapter:

(1) “Amniotic fluid” means the fluid inside the amnion;

(2) “Nonembryonic stem cell research” means medical research involving stem cells that have not been derived from a human embryo or fetus;

(3) “Placenta” means the organ that forms on the inner wall of the human uterus during pregnancy;

(4) “Postnatal tissue and fluid” means the placenta, umbilical cord, and amniotic fluid expelled or extracted in connection with the birth of a human being;

(5) “Stem cell” means an unspecialized or undifferentiated cell that can self-replicate and has the potential to differentiate into a specialized cell type; and

(6) “Umbilical cord” means the gelatinous tissue and blood vessels connecting an unborn human being to the placenta.

History. Acts 2007, No. 695, § 1.

20-8-504. Newborn Umbilical Cord Blood Initiative.

(a)(1) On or before June 30, 2008, the Arkansas Commission for the Newborn Umbilical Cord Blood Initiative shall establish a network of postnatal tissue and fluid banks in partnership with one (1) or more public or private colleges or universities, public or private hospitals, nonprofit organizations, or private firms in this state for the purpose of collecting and storing postnatal tissue and fluid.

(2) The Newborn Umbilical Cord Blood Bank shall create a voluntary program to make tissue and fluid available for scientific research and medical treatment in accordance with this subchapter.

(3) A parent of a child born in this state may voluntarily contribute postnatal tissue and fluid to the Newborn Umbilical Cord Blood Bank.

(b)(1) The commission shall develop a voluntary program to educate pregnant patients with respect to the banking of postnatal tissue and fluid.

(2) The program shall include:

(A) An explanation of the difference between public and private postnatal tissue and fluid banking programs;

(B) The medical process involved in the collection and storage of postnatal tissue and fluid;

(C) The current and potential future medical uses of stored postnatal tissue and fluid;

(D) The benefits and risks involved in the banking of postnatal tissue and fluid; and

(E) The availability and cost of storing postnatal tissue and fluid in public and private umbilical cord blood banks.

History. Acts 2007, No. 695, § 1.

20-8-505. Arkansas Commission for the Newborn Umbilical Cord Blood Initiative — Creation — Members.

(a) The Arkansas Commission for the Newborn Umbilical Cord Blood Initiative is created.

(b)(1) The commission shall consist of eleven (11) members appointed as follows:

(A) Three (3) members appointed by the Governor as follows:

(i) One (1) member who is a physician licensed by the Arkansas State Medical Board;

(ii) One (1) member who has a financial background; and

(iii) One (1) member who has a legal background or an ethicist background, or both;

(B) Three (3) members appointed by the Speaker of the House of Representatives as follows:

(i) One (1) member who is a physician licensed by the Arkansas State Medical Board;

(ii) One (1) member who has a financial background; and

(iii) One (1) member who has a legal background or an ethicist background, or both;

(C) Three (3) members appointed by the President Pro Tempore of the Senate as follows:

(i) One (1) member who is a physician licensed by the Arkansas State Medical Board;

(ii) One (1) member who has a financial background; and

(iii) One (1) member who has a legal background or an ethicist background, or both;

(D) The Dean of the Fay W. Boozman College of Public Health of the University of Arkansas for Medical Sciences or his or her designee; and

(E) The Director of the Department of Health or his or her designee.

(2) The commission shall include one (1) consultant, nonvoting member who shall be the Director of Cell Therapy and Transfusion Medicine of the University of Arkansas for Medical Sciences.

(c) The Governor shall designate one (1) member as chair of the commission.

(d) The chair shall call the first meeting of the commission within sixty (60) days of his or her appointment.

(e)(1) At the first meeting of the commission, the members shall draw lots so that three (3) members serve two-year terms, three (3) members serve three-year terms, and three (3) members serve four-year terms.

(2) After the initial terms, members shall serve four-year terms.

(f) The commission shall meet at least one (1) time per year.

(g)(1) A majority of the membership of the commission shall constitute a quorum.

(2) A majority vote of those members present shall be required for any action of the commission.

(h) Vacancies on the commission due to death, resignation, removal, or other causes shall be filled in the same manner as is provided in this section for initial appointments.

History. Acts 2007, No. 695, § 1; 2016 (3rd Ex. Sess.), No. 2, § 34; 2016 (3rd Ex. Sess.), No. 3, § 34.

A.C.R.C. Notes. Identical Acts 2016 (3rd Ex. Sess.), Nos. 2 and 3, § 1, provided:

“(a) The General Assembly finds:

“(1) State government provides vital functions that impact the lives of Arkansas citizens on a daily basis;

“(2) While these functions are important, it is equally important to ensure that state government operates efficiently and effectively to eliminate unnecessary spending of tax dollars and provide timely and quality services to Arkansas citizens; and

“(3) Issues such as the administrative organization of a governmental entity, the appointment structure of a governmental entity’s governing board, and extraneous

duties assigned to governmental entities hamper the operation of state government and result in unnecessary expenses and delays in the provision of state services.

“(b) It is the intent of this act to amend provisions of law applicable to certain agencies, task forces, committees, and commission to promote efficiency and effectiveness in the operations of state government as a whole.”

Amendments. The 2016 (3rd Ex. Sess.) amendment by identical acts Nos. 2 and 3 substituted “one (1) time per year” for “quarterly” at the end of (f).

20-8-506. Arkansas Commission for the Newborn Umbilical Cord Blood Initiative — Powers and duties.

(a) The Arkansas Commission for the Newborn Umbilical Cord Blood Initiative shall:

(1) Investigate the implementation of this subchapter and recommend improvements in this subchapter to the General Assembly;

(2) Make available to the public the records of all meetings of the commission and of all business transacted by the commission;

(3) Oversee the operations of the Newborn Umbilical Cord Blood Bank, including without limitation the approval of all fees established to cover administration, collection, and storage costs;

(4) Undertake the Newborn Umbilical Cord Blood Initiative by promoting awareness of the blood bank and encouraging donation of postnatal tissue and fluid to the blood bank;

(5) Ensure the privacy of persons who donate umbilical cord blood, amniotic fluid, and placental tissue to the blood bank;

(6) Develop a plan for making postnatal tissue and fluid collected under the Newborn Umbilical Cord Blood Initiative available for scientific research and medical treatment in compliance with all relevant national practice and quality standards;

(7) Develop a plan for private storage of postnatal tissue and fluid for medical treatment;

(8) Participate in the National Cord Blood Program and register postnatal tissue and fluid collected with registries operating in connection with the National Cord Blood Program;

(9) If funds are available, employ staff and enter into contracts necessary to implement this subchapter; and

(10) Report annually to the General Assembly on or before October 1 of each year concerning the activities of the commission.

(b) The commission may seek additional funding from any source, including without limitation federal grants and private grants.

History. Acts 2007, No. 695, § 1.

SUBCHAPTER 6 — ALZHEIMER’S ADVISORY COUNCIL

SECTION.
20-8-601 — 20-8-604. [Expired.]

20-8-601 — 20-8-604. [Expired.]

A.C.R.C. Notes. Identical Acts 2016 (3rd Ex. Sess.), Nos. 2 and 3, § 127, provided: “Sections of the Arkansas Code amended by this act that expire on or before September 30, 2017, may be removed from the Arkansas Code by the Arkansas Code Revision Commission after their respective expiration date.”

SUBCHAPTER 7 — PALLIATIVE CARE

SECTION.	SECTION.
20-8-701. Definitions.	Force — Creation — Membership.
20-8-702. Palliative Care and Quality of Life Interdisciplinary Task	20-8-703. Reports.

20-8-701. Definitions.

As used in this subchapter:

- (1) “Palliative care” means patient-centered and family-centered medical care offered throughout the continuum of an illness that optimizes quality of life by anticipating, preventing, and treating the suffering caused by a serious illness to address physical, emotional, social, and spiritual needs and facilitate patient autonomy, access to information, and choice, including without limitation:
 - (A) Discussion of the patient’s goals for treatment;
 - (B) Discussions of treatment options appropriate to the patient, including hospice care, if needed; and
 - (C) Comprehensive pain and symptom management; and
- (2) “Serious illness” means a medical illness or physical injury or condition that substantially impacts quality of life for more than a short period of time, including without limitation cancer, renal failure, liver failure, heart disease, lung disease, and Alzheimer’s disease and related dementia.

History. Acts 2017, No. 735, § 1.

20-8-702. Palliative Care and Quality of Life Interdisciplinary Task Force — Creation — Membership.

- (a) There is created the Palliative Care and Quality of Life Interdisciplinary Task Force.
- (b) The task force shall consist of thirteen (13) members as follows:
 - (1) Nine (9) members appointed by the Governor as follows:
 - (A) One (1) member who is a designee of the American Cancer Society;
 - (B) One (1) member who is a designee of the Hospice and Palliative Care Association of Arkansas, Inc.;

(C) One (1) member who is a designee of the Department of Veterans Affairs;

(D) One (1) member who is a designee of the American Heart Association, Arkansas Affiliate, Inc.;

(E) One (1) member who is a designee of the Arkansas Hospital Association, Inc.;

(F) One (1) member who is a designee of the Arkansas Medical Society, Inc.;

(G) One (1) member who is a designee of the Arkansas Health Care Association;

(H) One (1) member who is a designee of the Arkansas Center for Health Improvement; and

(I) One (1) member, in consultation with the Surgeon General, who is a palliative care professional with expertise in the following knowledge areas that may include without limitation:

(i) Interdisciplinary palliative care;

(ii) Medical, nursing, social work, pharmacy, or spiritual services;

(iii) Psychosocial issues involved in caregiving for patient and family caregivers or their advocates; and

(iv) Palliative care perspectives and challenges across multiple settings, including inpatient, outpatient, and community settings, and across pediatric, youth, adult, and geriatric populations;

(2) Two (2) members appointed by the President Pro Tempore of the Senate as follows:

(A) One (1) member who is a board-certified hospice and palliative medicine physician, physician assistant, or nurse; and

(B) One (1) member, in consultation with the Surgeon General, who is a palliative care professional with expertise in the following knowledge areas that may include without limitation:

(i) Interdisciplinary palliative care;

(ii) Medical, nursing, social work, pharmacy, or spiritual services;

(iii) Psychosocial issues involved in caregiving for patient and family caregivers or their advocates; and

(iv) Palliative care perspectives and challenges across multiple settings, including inpatient, outpatient, and community settings, and across pediatric, youth, adult, and geriatric populations; and

(3) Two (2) members appointed by the Speaker of the House of Representatives as follows:

(A) One (1) member who is a board-certified hospice and palliative medicine physician, physician assistant, advanced practice registered nurse, or nurse; and

(B) One (1) member, in consultation with the Surgeon General, who is a palliative care professional with expertise in the following knowledge areas that may include without limitation:

(i) Interdisciplinary palliative care;

(ii) Medical, nursing, social work, pharmacy, or spiritual services;

(iii) Psychosocial issues involved in caregiving for patient and family caregivers or their advocates; and

(iv) Palliative care perspectives and challenges across multiple settings, including inpatient, outpatient, and community settings, and across pediatric, youth, adult, and geriatric populations.

(c) The members of the task force shall be appointed by September 1, 2017.

(d) In the event of a vacancy in the membership of the task force, a person shall be appointed by the appropriate individual and who meets the applicable eligibility requirements of the vacated position to fill the vacancy for the remainder of the term.

(e)(1) The task force shall select a chair and vice chair during the first meeting.

(2) The task force shall hold at least two (2) regular meetings in each calendar year at a time and place determined by the task force.

(f) Seven (7) members of the task force shall constitute a quorum to transact business.

(g) The members of the task force may receive expense reimbursement in accordance with § 25-16-901 et seq.

(h) The Department of Health, in conjunction with the Department of Human Services, shall provide staff, information, and other assistance as reasonably necessary to assist the task force in its efficient organization.

(i) The purpose of the task force is to consult with and advise the Department of Health on matters relating to the establishment, maintenance, operation, and outcome evaluation of palliative care initiatives in the state.

(j) The task force shall expire on December 31, 2019, unless extended by the General Assembly.

History. Acts 2017, No. 735, § 1.

20-8-703. Reports.

(a) The Palliative Care and Quality of Life Interdisciplinary Task Force shall submit a preliminary report to the Governor, President Pro Tempore of the Senate, and the Speaker of the House of Representatives on or before January 17, 2019, that includes without limitation:

(1) Recommendations for the establishment, maintenance, operation, and outcome evaluation of palliative care initiatives in the state; and

(2) Recommendations for any statutory changes to be considered by the General Assembly.

(b) The task force shall submit a follow-up report to the Governor, President Pro Tempore of the Senate, and the Speaker of the House of Representatives on or before December 31, 2020, detailing the implementation of the recommendations from the preliminary report.

(c) On and after August 1, 2017, the task force shall submit and present a quarterly report to the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare, and Labor.

History. Acts 2017, No. 735, § 1.

SUBCHAPTER 8 — VOLUNTEER HEALTH CARE ACT

SECTION.

- 20-8-801. Title.
- 20-8-802. Legislative purpose.
- 20-8-803. Definitions.
- 20-8-804. Volunteer Healthcare Program.
- 20-8-805. Continuing education credit.

SECTION.

- 20-8-806. Notice of agency relationship.
- 20-8-807. Reports.
- 20-8-808. Malpractice litigation costs.
- 20-8-909. Rule promulgation.

20-8-801. Title.

This subchapter shall be known and may be cited as the “Volunteer Health Care Act”.

History. Acts 2017, No. 958, § 1.

20-8-802. Legislative purpose.

It is the purpose of the General Assembly to:

- (1) Provide and facilitate access to appropriate, safe, and cost-effective healthcare services; and
- (2) Maintain healthcare quality.

History. Acts 2017, No. 958, § 1.

20-8-803. Definitions.

As used in this subchapter:

- (1) “Contract” means an agreement executed in compliance with this subchapter between a healthcare professional or a medical professional and the Department of Health or a governmental contractor;
- (2) “Governmental contractor” means the county health units, special purpose districts with healthcare responsibilities, a hospital owned and operated by a governmental entity, or any other healthcare entity designated by the department;
- (3) “Healthcare provider” means:
 - (A) A free or charitable healthcare clinic qualified as exempt from federal income taxation;
 - (B) A state or federally funded community health center;
 - (C) A volunteer corporation or volunteer healthcare provider that delivers healthcare services to low-income patients; and
 - (D) Other medical facilities with the primary purpose to deliver medical services or treatment to humans and that include an office maintained by a medical professional;
- (4) “Low-income patient” means a person who:
 - (A) Is eligible for any category of the Arkansas Medicaid Program;
 - or
 - (B) Does not have health insurance and whose annual household income does not exceed three hundred percent (300%) of the federal poverty level; and

(5) “Medical professional” means:

- (A) A physician, osteopathic physician, or optometric physician;
- (B) An osteopathic physician’s assistant, physician’s assistant, or optometric physician’s assistant;
- (C) A chiropractic physician;
- (D) A podiatric physician;
- (E) A nurse licensed under § 17-87-101 et seq.;
- (F) A dentist or dental hygienist;
- (G) A pharmacist;
- (H) An optometrist;
- (I) A dietitian or an individual who offers dietary services; and
- (J) A student enrolled in an accredited program that prepares the student for licensure in one (1) or more of the healthcare professions listed in subdivisions (5)(A)-(H) of this section.

History. Acts 2017, No. 958, § 1.

20-8-804. Volunteer Healthcare Program.

(a)(1) A healthcare provider or medical professional may enter into a contract with the Department of Health or governmental contractor to deliver volunteer health services to eligible low-income patients.

(2) A healthcare provider or medical professional that enters into a contract as described in subdivision (a)(1) of this section shall be an agent of the state with sovereign immunity while the healthcare provider or medical professional is acting within the scope of duties under the contract as described in this subchapter.

(3) A governmental contractor that is also a healthcare provider is not required to enter into a contract under this subchapter with respect to the healthcare services delivered by employees of the governmental contractor.

(b) The contract shall:

(1) Apply only to volunteer healthcare services delivered by the healthcare provider or medical professional to low-income patients who are eligible to receive healthcare services;

(2) Include all employees of the healthcare provider; and

(3) State that:

(A) The healthcare provider or medical professional has sovereign immunity and may not be named as a defendant in an action arising due to medical care or treatment provided within the scope of the contract;

(B) If a patient treated by the healthcare provider or medical professional is ineligible for services, the healthcare provider or medical professional shall still have sovereign immunity and may not be named as a defendant in an action arising due to medical care or treatment provided;

(C) The department or the governmental contractor has the right to:

(i) Dismiss or terminate any healthcare provider or medical professional employed under the contract; and

(ii)(a) Terminate the contact with a healthcare provider or medical professional with appropriate cause.

(b) At least five (5) business days before the termination date of a contract, the department or governmental contractor shall provide the healthcare provider or medical professional with written notice of intent to terminate the contract and reasons for the decision; and

(iii) Access the records of any patient served by the healthcare provider or medical professional under the contract;

(D)(i) The healthcare provider or medical professional shall report any adverse incidents and information on treatment outcomes to the department or governmental contractor if pertaining to a patient treated under the contract.

(ii) The healthcare provider or medical professional shall also report the adverse incident to the appropriate licensing body to determine whether the adverse incident involves conduct subject to disciplinary action.

(iii) Patient medical records and identifying information contained in the adverse incident report shall be confidential and not subject to the Freedom of Information Act of 1967, § 25-19-101 et seq.;

(E) The department, governmental contractor, healthcare provider, or medical provider may make patient selection and initial referrals; and

(F) If emergency care is required, the patient shall be referred within forty-eight (48) hours after the latter of the time when treatment commences or the patient has the mental capacity to consent to treatments.

(c) Annually, the healthcare provider or medical professional shall report the following information to the department:

(1) A summary of the efficacy of access and treatment outcomes;

(2) Statistics for claims pending and claims paid;

(3) The amount of defense and handling costs associated with all claims brought against healthcare providers or medical professionals by the healthcare provider or medical professional working under the Volunteer Healthcare Program;

(4) The operation hours of the healthcare provider or medical professional;

(5) The number of patient visits by the healthcare provider or medical professional working under the Volunteer Healthcare Program; and

(6) The value of healthcare-related goods and services provided by the healthcare provider or medical professional working under the Volunteer Healthcare Program.

20-8-805. Continuing education credit.

(a) A medical professional may fulfill one (1) hour of continuing education credit with the performance of eight (8) hours of volunteer services under this subchapter.

(b) A medical professional shall not obtain more than eight (8) hours of credits as described in subsection (a) of this section in a licensing period.

History. Acts 2017, No. 958, § 1.

20-8-806. Notice of agency relationship.

(a) The healthcare provider or medical professional shall provide written notice to each patient, parent of the patient, or legal guardian of the patient served under a contract described in this subchapter.

(b) The written notice shall:

(1) Be acknowledged in writing by the patient, the parent of the patient, or the legal guardian of the patient; and

(2) Contain information that:

(A) The healthcare provider or medical professional is an agent of the state; and

(B) The exclusive remedy for damage or injury suffered as a result of any act or omission by the healthcare provider or medical professional acting within the scope of duties under a contract described in this subchapter is to file a claim in the Arkansas State Claims Commission.

(c) The healthcare provider or medical professional may comply with the requirements of subdivisions (b)(2)(A) and (B) of this section by posting the notice in a conspicuous place within the place of business of the healthcare provider or medical professional.

History. Acts 2017, No. 958, § 1.

20-8-807. Reports.

(a) Annually, the Department of Health shall report to:

(1) The President Pro Tempore of the Senate;

(2) The Speaker of the House of Representatives;

(3) The minority leaders of the Senate and the House of Representatives;

(4) The Chair of the Senate Committee on Public Health, Welfare, and Labor; and

(5) The Chair of the House Committee on Public Health, Welfare, and Labor.

(b) The report shall include without limitation:

(1) A summary of the efficacy of access and treatment outcomes;

(2) Statistics for claims pending and claims paid;

(3) The amount of defense and handling costs associated with all claims brought against healthcare providers or medical professionals under the Volunteer Healthcare Program;

(4) A listing of all healthcare providers and medical professionals volunteering under the Volunteer Healthcare Program with the operation hours of each healthcare provider and medical professional;

(5) The number of patient visits under the Volunteer Healthcare Program; and

(6) The value of healthcare-related goods and services provided by the Volunteer Healthcare Program.

History. Acts 2017, No. 958, § 1.

20-8-808. Malpractice litigation costs.

A governmental contractor is responsible for costs and attorney's fees for malpractice litigation arising out of healthcare services delivered under a contract brought to the Arkansas State Claims Commission.

History. Acts 2017, No. 958, § 1.

20-8-809. Rule promulgation.

The Department of Health shall promulgate rules necessary to implement this subchapter in a manner consistent with the purpose of this subchapter.

History. Acts 2017, No. 958, § 1.

CHAPTER 9

HEALTH FACILITIES AND SERVICES GENERALLY

SUBCHAPTER.

1. GENERAL PROVISIONS.
2. HEALTH FACILITIES SERVICES.
3. HOSPITALS, CLINICS, ETC. — MISCELLANEOUS PROVISIONS.
4. FREESTANDING BIRTHING CENTERS.
5. PEER REVIEW COMMITTEES.
6. CONSENT TO TREATMENT.
7. MEDICARE.
8. TRANSPLANTS.
9. UTILIZATION REVIEW.
10. ACUTE STROKE CARE ACT OF 2005.
11. CERVICAL CANCER CARE ACT OF 2005.
12. HEALTH FACILITY INFECTION DISCLOSURE ACT OF 2007.
13. ARKANSAS PEER REVIEW FAIRNESS ACT.
14. CARTER'S LAW: THE SHAKEN BABY SYNDROME EDUCATION PROGRAM.

SUBCHAPTER 1 — GENERAL PROVISIONS

SECTION.

20-9-101. Professional health service personnel — Parity.

20-9-102. [Repealed.]

SECTION.

20-9-103. Pulse oximetry screening — Definition.

Cross References. Medical Corporation Act, § 4-29-301 et seq.

Effective Dates. Acts 1991, No. 1085, § 35: July 1, 1991. Emergency clause provided: "It is hereby found and determined by the Seventy-Eighth General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness of this Act on July 1, 1991 is essential to the operation of the agency for which the appropriations in

this Act are provided, and that in the event of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1, 1991 could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 1991."

20-9-101. Professional health service personnel — Parity.

(a) Any additional compensation or allowances which may be made available to professional health service personnel at the University of Arkansas for Medical Sciences campus may also be made available to those in comparable positions in all divisions or offices of the Department of Human Services.

(b) Professional health service personnel shall be limited to all nursing, occupational therapy, and physical therapy classifications.

History. Acts 1991, No. 1085, § 26.

A.C.R.C. Notes. Former § 20-9-101, concerning health professionals parity, is deemed to be superseded by this section. The former section was derived from Acts

1989 (1st Ex. Sess.), No. 68, § 14. A similar provision which was also codified as § 20-9-101, and was previously superseded, was derived from Acts 1985, No. 772, § 1.

20-9-102. [Repealed.]

Publisher's Notes. This section, concerning shaken baby syndrome educational materials, was repealed by Acts

2013, No. 1208, § 1. The section was derived from Acts 2011, No. 1128, § 1.

20-9-103. Pulse oximetry screening — Definition.

(a) As used in this section, "birthing facility" means an inpatient or ambulatory healthcare facility licensed by the Department of Health that provides birthing services or newborn care services, or both.

(b) Birthing facilities shall begin pulse oximetry testing for critical congenital heart defects on all newborns before discharge from the birthing facility no fewer than ninety (90) days and no more than one hundred eighty (180) days after the Department of Health complies

with subsection (d) of this section.

(c) To facilitate pulse oximetry testing for critical congenital heart defects on all newborns in the State of Arkansas before discharge from a birthing facility, Arkansas Children's Hospital shall:

(1) Provide written guidance on evidence-based guidelines on development of hospital policies and procedures related to pulse oximetry screening in newborns to the Department of Health and, on request, to an individual birthing facility;

(2) Provide the Department of Health with an educational document that may be distributed to parents or legal guardians of newborns regarding:

(A) The need for and performance of the pulse oximetry test;

(B) Methods for conducting the screening; and

(C) Common strategies for follow-up care in infants with abnormal screening results; and

(3) Through its Department of Pediatrics, provide to a birthing facility training and on-site technical assistance upon request in the performance of pulse oximetry testing.

(d) To facilitate pulse oximetry testing for critical congenital heart defects on all newborns in the State of Arkansas before discharge from a birthing facility, the Department of Health shall:

(1) Develop an appropriate and functional system allowing for electronic submission of pulse oximetry test results by the hospital; and

(2) Provide technical assistance and training to the birthing facilities on the use of the system.

(e) Testing results submitted to and compiled by the Department of Health under this section are confidential and are not subject to examination or disclosure as public information under the Freedom of Information Act of 1967, § 25-19-101 et seq.

(f) The Department of Health shall not require the performance of a pulse oximetry test on a newborn if the parents or a legal guardian of the newborn object to the testing on medical, religious, or philosophical grounds.

History. Acts 2013, No. 768, § 2.

A.C.R.C. Notes. Acts 2013, No. 768, § 1, provided: "Findings. The General Assembly finds that:

"(1) Congenital heart defects:

"(A) Are structural abnormalities of the heart that are present at birth;

"(B) Range in severity from simple problems such as holes between chambers of the heart, to severe malformations such as complete absence of one (1) or more chambers of the heart;

"(C) May cause severe and life-threatening symptoms that require intervention within the first (5) days of birth; and

"(D) Are the number one killer of infants with birth defects;

"(2) Each year approximately fifty (50) infants out of approximately forty thousand (40,000) infants born in Arkansas will have a critical congenital heart defect;

"(3) In Arkansas, the infant mortality rate is seven-tenths percent of one percent (0.7%), while mortality among infants with a critical congenital heart defect is twenty-four and eight-tenths percent (24.8%);

"(4) Hospital costs for all infants with congenital heart defects can total two billion, six hundred million dollars (\$2,600,000,000) per year, while the estimated cost of critical congenital heart defect screening with pulse oximetry is one dollar (\$1.00) per year to ten dollars

(\$10.00) per year, per infant depending on the equipment and personnel performing the test;

“(5)(A) Current methods for detecting congenital heart defects generally include prenatal ultrasound screening and repeated clinical examinations designed to identify affected newborns.

“(B) The screenings alone identify less than one half (½) of all cases, and critical congenital heart defect cases are often missed during routine clinical exams performed before the newborn’s discharge from a birthing facility;

“(6) Pulse oximetry is a noninvasive test that:

“(A) Estimates the percentage of hemoglobin in blood that is saturated with oxygen; and

“(B) When performed on newborns in delivery centers is effective at detecting critical, life-threatening congenital heart defects that otherwise go undetected by current screening methods;

“(7) Newborns with abnormal pulse oximetry results require immediate confirmatory testing and intervention; and

“(8) Many newborns’ lives potentially could be saved by earlier detection and treatment of congenital heart defects if birthing facilities in Arkansas were required to perform this simple, noninvasive newborn screening in conjunction with current congenital heart disease screening methods.”

SUBCHAPTER 2 — HEALTH FACILITIES SERVICES

SECTION.

- 20-9-201. Definitions.
- 20-9-202. Penalties.
- 20-9-203. Injunction.
- 20-9-204. Administration by Division of Health Facilities Services.
- 20-9-205. Powers and duties of State Board of Health.
- 20-9-206. Construction program — Survey and planning activities.
- 20-9-207. Construction program — Federal funds for surveying and planning.
- 20-9-208. Construction program — State plan.
- 20-9-209. Construction program — Application for funds.
- 20-9-210. Construction program — Payment of installments.
- 20-9-211. Construction program — Federal funds.

SECTION.

- 20-9-212. Minimum standards for hospitals and other institutions.
- 20-9-213. License required — Administration by State Board of Health.
- 20-9-214. Issuance of license — Fees.
- 20-9-215. License — Denial, suspension, and revocation.
- 20-9-216. License — Judicial review.
- 20-9-217. Alterations, additions, and new construction of facilities.
- 20-9-218. Emergency services facilities.
- 20-9-219. Inspections of facilities — Definitions.
- 20-9-220. Annual report.
- 20-9-221. Information confidential.
- 20-9-222. Certification fee.
- 20-9-223. Medical office licensure.

A.C.R.C. Notes. References to “this subchapter” in §§ 20-9-201 — 20-9-221 may not apply to § 20-9-222 which was enacted subsequently.

Publisher’s Notes. Acts 1961, No. 414, § 1, provided that Acts 1961, No. 414 (§§ 20-9-202 — 20-9-221) could be cited as the “Division of Hospital and Nursing Homes Act.”

Acts 1961, No. 414, § 29, provided, in part, that the specific intent of that act

was to vest sole authority to license hospitals and nursing homes in the State Department of Public Health (now Department of Health).

Acts 1961, No. 414, codified in this subchapter, is also codified as §§ 20-10-214 — 20-10-228.

Preambles. Acts 1999, No. 506 contained a preamble which read:

“WHEREAS, the Arkansas Department of Health has been charged with the

responsibility for conducting surveys of inpatient hospital facilities to ensure that each complies with the rules and regulations adopted by the Arkansas State Department of Health; and

"WHEREAS, the Joint Commission on Accreditation of Healthcare Organizations performs rigorous surveys in connection with its accreditation process, refusing accreditation to those hospitals which do not meet the Joint Commission on Accreditation of Healthcare Organizations' standards; and

"WHEREAS, many hospitals choose to engage the Joint Commission on Accreditation of Healthcare Organizations to perform surveys in order to receive accreditation; and

"WHEREAS, the Joint Commission on Accreditation of Healthcare Organization is recognized for the rigor of its surveys, which are performed on a regular schedule; and

"WHEREAS, forty-four (44) states recognize surveys and accreditation by the Joint Commission on Accreditation of Healthcare Organizations as adequate substitutes for state surveys and accordingly deem them to be sufficient to meet survey requirements; and

"WHEREAS, the duplicate surveys are costly to hospitals, leading to costs which are higher than would be necessary if only one (1) survey was required; and

"WHEREAS, it is in the public interest that Arkansas hospitals be surveyed by expert surveyors at the lowest cost for the provision of quality reviews.

"NOW THEREFORE, ..."

Effective Dates. Acts 1965, No. 454, § 5: Mar. 20, 1965. Emergency clause provided: "It is found and declared by the General Assembly of Arkansas that Sections 8 and 22 of Act 414 of 1961 do not meet requirements of the Federal Government to qualify the State to receive Federal moneys to carry out the purposes of Act 414 of 1961, and that there is great need for such Federal funds to be immediately obtained, therefore, an emergency is hereby declared to exist, and this Act being necessary for the immediate preservation of public peace, health and safety, shall take effect and be in full force from and after its passage and approval."

Acts 1971, No. 258, § 5: became law without Governor's signature, Mar. 9, 1971. Emergency clause provided: "It is

found and declared by the General Assembly of Arkansas that Act 414 of 1961, and amendments thereto, does not clearly provide the State Board of Health with the authority to license, inspect and regulate Recuperation Centers, that such intermediate health care facilities are desirable and necessary, and that there is great need for such authority to be clearly and immediately established. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the preservation of the public peace, health and safety, shall be in full force and effect from the date of its passage and approval."

Acts 1975, No. 190, § 4: Feb. 18, 1975. Emergency clause provided: "It is hereby found and determined by the General Assembly that there is an urgent need in this State for outpatient surgery centers as defined herein to relieve the severe overcrowding of hospital facilities; that such centers will serve an urgent need of the citizens of this State for additional facilities where minor surgery may be performed without the necessity of entering a hospital and incurring the much higher costs of a hospital, and that this Act should be given effect immediately to permit the establishment and operation of such facilities. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1977, No. 536, § 4: Mar. 18, 1977. Emergency clause provided: "It is hereby found and determined by the General Assembly that there is an urgent need in this State for outpatient psychiatric centers as defined herein to relieve the severe overcrowding of hospital facilities; that such centers will serve an urgent need of the citizens of this State for additional facilities where psychiatric services may be provided without the necessity of entering a hospital and incurring the much higher costs of a hospital, and that this Act should be given effect immediately to permit the establishment and operation of such facilities. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1983, No. 273, § 3: Feb. 25, 1983. Emergency clause provided: "It is hereby found and determined by the General Assembly that the length and variety of billing forms now used by third-party carriers is an important source of administrative expense for hospitals and patients; that hospital cost containment is essential to the health, safety and welfare of the people and should be encouraged; and that a uniform billing form, if implemented without delay, will provide a significant savings in hospital costs in this State. Therefore an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1987, No. 516, § 3: Apr. 1, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that some hospitals around the State are discontinuing their in-patient services and as a result also are closing their emergency room services; that this Act would allow the continued operation of hospital emergency services even when the in-patient services have been discontinued; that until this Act becomes effective some portions of the State may be without adequate hospital emergency services and therefore this Act should go into effect immediately. Therefore, an emergency is hereby declared to exist and this Act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

RESEARCH REFERENCES

Am. Jur. 40A Am. Jur. 2d, Hospitals, §§ 5, 6.

C.J.S. 41 C.J.S., Hospitals, §§ 8-11.

20-9-201. Definitions.

As used in this subchapter:

(1) "Administrator" means the chief administrative officer in the Division of Health Facilities Services;

(2) "Alcohol and drug abuse inpatient treatment center" means a distinct unit within a hospital facility in which services are provided for the diagnosis, treatment, and rehabilitation of alcohol and drug abuse;

(3) "Federal act" means the Hospital Survey and Construction Act, Pub. L. No. 79-725;

(4)(A) "Hospital" means a public health center, a general, tuberculosis, mental, or chronic disease hospital, or a related facility such as a laboratory, outpatient department, nurses home or training facility, or a central service facility operated in connection with a hospital.

(B) "Hospital" does not include an establishment:

(i) Furnishing primarily domiciliary care; or

(ii) Licensed or certified by the Division of Aging, Adult, and Behavioral Health Services of the Department of Human Services as an alcohol and drug abuse inpatient treatment center;

(5)(A) "Institution" means a place for the diagnosis, treatment, or care of two (2) or more persons not related to the proprietor, suffering from illness, injury, or deformity, or where obstetrical care or care of the aged, blind, or disabled is rendered over a period exceeding twenty-four (24) hours.

(B) "Institution" also includes an outpatient surgery center, out-

patient psychiatric center, and infirmary.

(C) "Institution" does not include an establishment:

(i) Operated by the United States Government or by any of its agencies; or

(ii) Licensed or certified by the Division of Aging, Adult, and Behavioral Health Services of the Department of Human Services as an alcohol and drug abuse inpatient treatment center;

(6) "Medical facility" means a diagnostic or diagnostic and treatment center, or rehabilitation facility, as these terms are defined in the federal act, and any other medical facility for which federal aid may be authorized under federal law;

(7) "Nonprofit hospital" or "nonprofit medical facility" means a hospital or medical facility owned and operated by one (1) or more persons or a corporation or association, no part of the net earnings of which inures to the benefit of any shareholder or individual;

(8)(A) "Outpatient psychiatric center" means a facility in which psychiatric services are offered for a period of eight (8) to sixteen (16) hours a day, and where, in the opinion of the attending psychiatrist, hospitalization, as defined in the present licensure law, is not necessary.

(B) "Outpatient psychiatric center" does not include community mental health clinics and centers as they now exist;

(9)(A) "Outpatient surgery center" means a facility in which surgical services are offered that require the use of general or intravenous anesthetics and where, in the opinion of the attending physician, hospitalization, as defined in the present licensure law, is not necessary.

(B) "Outpatient surgery center" does not include:

(i) A medical office owned and operated by a physician or more than one (1) physician licensed by the Arkansas State Medical Board, if the medical office does not bill facility fees to a third party payor; or

(ii) A dental office that has a Facility Permit for Moderate Sedation or a Facility Permit for General/Deep Sedation issued by the Arkansas State Board of Dental Examiners;

(10) "Public health center" means a publicly owned facility for the provision of public health services and includes related facilities such as laboratories, clinics, and administrative offices operated in connection with public health centers;

(11)(A) "Recuperation center" means an establishment with permanent facilities that include inpatient beds, with an organized medical staff, and with medical services including physicians' services and continuous nursing services to provide treatment for patients who are not in an acute phase of illness but who currently require primarily convalescent or restorative service that is usually post-acute hospital care of relatively short duration.

(B) "Recuperation center" does not include an establishment furnishing primarily domiciliary care; and

(12) "Surgeon General" means the United States Surgeon General.

History. Acts 1961, No. 414, § 2; 1971, No. 258, § 1; 1975, No. 190, §§ 1, 2; 1977, No. 536, §§ 1, 2; 1985, No. 980, §§ 1, 2; A.S.A. 1947, § 82-328; Acts 1987, No. 143, § 1; 2011, No. 834, § 1; 2013, No. 587, § 3; 2013, No. 1107, § 18; 2017, No. 913, §§ 54, 55.

Amendments. The 2013 amendment by No. 587 redesignated former (9) as (9)(A); deleted “other than minor dental surgery” following “surgical services” in (9)(A); and added (9)(B).

The 2013 amendment by No. 1107 substituted “Division of Behavioral Health

Services” for “Office of Alcohol and Drug Abuse Prevention of the Division of Behavioral Health” in (4)(B)(ii) and (5)(C)(ii).

The 2017 amendment substituted “Division of Aging, Adult, and Behavioral Health Services of the Department of Human Services” for “Division of Behavioral Health Services” in (4)(B)(ii) and (5)(C)(ii).

U.S. Code. The Hospital Survey and Construction Act, Pub. L. No. 79-725, referred to in this section has, for the most part, been eliminated from the United States Code. For remaining provisions, see 48 U.S.C. § 1666 and 42 U.S.C. § 291.

RESEARCH REFERENCES

U. Ark. Little Rock L.J. Survey of Arkansas Law, Insurance, 1 U. Ark. Little Rock L.J. 210.

CASE NOTES

Cited: *Raney v. Raulston*, 238 Ark. 875, 385 S.W.2d 651 (1965).

20-9-202. Penalties.

(a) Any person, partnership, association, or corporation establishing, conducting, managing, or operating any institution without first obtaining a license therefor as provided or violating any provision of this subchapter or regulations lawfully promulgated under this subchapter shall be guilty of a violation.

(b) Upon conviction, the person shall be fined not less than twenty-five dollars (\$25.00) nor more than one hundred dollars (\$100) for the first offense and not less than one hundred dollars (\$100) nor more than five hundred dollars (\$500) for each subsequent offense.

(c) Each day the institution shall operate after a first conviction shall be considered a subsequent offense.

History. Acts 1961, No. 414, § 27; A.S.A. 1947, § 82-353; Acts 2005, No. 1994, § 104.

20-9-203. Injunction.

The State Board of Health may sue in the name of the state any person, partnership, association, or corporation in order to enjoin the establishing, conducting, managing, or operating of any institution within the meaning of this subchapter without the person’s first having secured a license therefor.

History. Acts 1961, No. 414, § 26; A.S.A. 1947, § 82-352.

20-9-204. Administration by Division of Health Facilities Services.

(a) There is established in the State Board of Health a Division of Health Facilities Services, which shall be administered by a full-time salaried administrator under the supervision and direction of the Director of the Department of Health.

(b) The Department of Health, through the division, is the sole agency of the state for the purpose of:

(1) Making an inventory of existing hospitals and medical facilities, surveying the need for construction of hospitals and medical facilities, and developing a program of construction as provided in this subchapter;

(2) Developing and administering a state plan for the construction of public and other nonprofit hospitals and medical facilities as provided; and

(3) Inspecting, regulating, and licensing hospitals and institutions.

History. Acts 1961, No. 414, § 3; A.S.A. 1947, § 82-329.

CASE NOTES**Regulations.**

The Department of Health regulations, promulgated pursuant to this section, which require hospitals to adopt written bylaws setting out the method of appointing the medical staff, the requirements for medical staff membership, and an appeal

process for physicians to follow in challenging adverse recommendations, do not constitute a form of state action which would give rise to a federal civil rights action by a physician disciplined by a private hospital. *Garst v. Stoco, Inc.*, 604 F. Supp. 326 (E.D. Ark. 1985).

20-9-205. Powers and duties of State Board of Health.

(a) In carrying out this subchapter, the State Board of Health is empowered and directed to:

(1) Require such reports, make such inspections and investigations, and prescribe and enforce such reasonable rules and regulations as it finds necessary to effectuate the purposes of this subchapter;

(2) Provide methods of administration and appoint an administrator and other personnel of the Division of Health Facilities Services;

(3) Procure and pay for the temporary services of experts or consultants on a fee-for-service basis;

(4) Enter into agreements for the utilization of the facilities and services of other departments, agencies, and institutions, public and private;

(5) Accept on behalf of the state, and deposit with the Treasurer of State, any grant, gift, or contribution of funds made to assist in meeting the cost of carrying out the purposes of this subchapter, and expend such funds accordingly;

(6) Make an annual report to the Governor on activities and expenditures made pursuant to this subchapter;

(7) Procure the services of an attorney to assist the Department of Health in any legal work involved in carrying out the duties of the department and to pay for the services on a fee-for-service or retainer basis; and

(8) Prescribe and enforce such reasonable rules and regulations as are necessary to adopt a uniform billing form for hospitals within the state and to prescribe penalties for the failure or refusal to utilize and accept such forms. However, the form must be acceptable by Medicare and its intermediaries within the state and consistent with the form adopted at the federal level by Medicare and the National Uniform Billing Committee.

(b) The department shall adopt, promulgate, and enforce such rules, regulations, and standards as may be necessary for the accomplishment of the purposes of this subchapter. The rules, regulations, and standards shall be modified, amended, or rescinded, from time to time, by the department as may be in the public interest.

History. Acts 1961, No. 414, §§ 4, 28; 1983, No. 273, § 1; A.S.A. 1947, §§ 82-330, 82-354.

20-9-206. Construction program — Survey and planning activities.

(a) The State Board of Health is empowered and directed to make an inventory of existing hospitals and medical facilities including public, nonprofit, and proprietary hospitals and medical facilities, to survey the need for construction of hospitals and medical facilities and, on the basis of the inventory and survey, to develop a program for the construction of such public and other nonprofit hospitals and medical facilities as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital and medical facility services to the people of the state in accordance with the regulations prescribed by the federal act.

(b) The construction program shall provide, in accordance with regulations prescribed by the federal act, for adequate hospital and medical facilities for the people of the state, and insofar as possible shall provide for their distribution throughout the state in such manner as to make all types of hospital and medical facility services reasonably accessible to all persons in the state.

History. Acts 1961, No. 414, §§ 9, 10; A.S.A. 1947, §§ 82-335, 82-336.

CASE NOTES

Cited: *Raney v. Raulston*, 238 Ark. 875, 385 S.W.2d 651 (1965).

20-9-207. Construction program — Federal funds for surveying and planning.

(a) The State Board of Health may make application to the United States Surgeon General for and receive federal funds to assist in carrying out the survey and planning activities provided in § 20-9-206(a) and § 20-10-217(a).

(b) The funds shall be deposited with the Treasurer of State as a trust fund designated the "Hospital and Medical Facility Survey and Planning Fund", which shall be kept separate and apart from all public funds of the state and shall be available to the Department of Health for expenditure in carrying out the survey and planning activities provided.

(c) Any funds received and not expended for such purposes shall be repaid to the United States Treasury.

(d) Warrants for all payments from the fund shall bear the signature of the Director of the Department of Health or his or her agent.

History. Acts 1961, No. 414, § 11;
A.S.A. 1947, § 82-337.

20-9-208. Construction program — State plan.

(a)(1) The State Board of Health shall prepare and submit to the United States Surgeon General a state plan which shall include the hospital and medical facilities construction program developed as provided in this subchapter. The plan shall provide for the establishment, administration, and operation of hospital and medical facilities construction activities in accordance with the requirements of the federal act and regulations thereunder.

(2) The state plan shall also set forth the relative need for the several projects included in the construction program determined in accordance with regulations prescribed by the federal act and provide for the construction, insofar as financial resources available for construction and for maintenance and operation permit, in the order of relative need.

(b) Before the submission of the plan to the United States Surgeon General, the Department of Health shall give adequate publicity to a general description of all the provisions proposed to be included therein and hold a public hearing at which all persons or organizations with a legitimate interest in the plan may be given an opportunity to express their views.

(c) After approval of the plan by the United States Surgeon General, the department shall cause to be published a general description of the provisions thereof in at least one (1) newspaper having general circulation in each county in the state and shall make the plan, or a copy thereof, available upon request to all interested persons or organizations.

(d) The department shall from time to time review the construction program, submit to the United States Surgeon General any modifications of the program which it may find necessary, and may submit to the

United States Surgeon General modifications of the state plan not inconsistent with the requirements of the federal act.

History. Acts 1961, No. 414, §§ 12, 14;
A.S.A. 1947, §§ 82-338, 82-340.

20-9-209. Construction program — Application for funds.

(a) Applications for hospital and medical facilities construction projects for which federal funds are requested shall be submitted to the State Board of Health and may be submitted by the state or any political subdivision thereof or by any public or other nonprofit agency authorized to construct and operate a hospital or a medical facility.

(b) However, no application for a diagnostic or treatment center shall be approved unless the applicant is:

(1) The state, a political subdivision, or a public agency; or

(2) A person, corporation, or association which owns and operates a nonprofit hospital.

(c) Each application for a construction project shall conform to federal and state requirements.

(d) If, after affording reasonable opportunity for development and presentation of applications in the order of relative need, the Department of Health finds that a project application complies with subsection (a) of this section and is otherwise in conformity with the state plan, then it shall approve the application and shall recommend and forward it to the United States Surgeon General.

(e) The department by regulation shall provide an opportunity for fair hearing and appeal to every applicant who is dissatisfied with any action regarding an application.

History. Acts 1961, No. 414, §§ 15, 16;
A.S.A. 1947, §§ 82-341, 82-342.

20-9-210. Construction program — Payment of installments.

The State Board of Health shall from time to time cause to be inspected each construction project approved by the United States Surgeon General. If the inspection warrants, the Department of Health shall certify to the United States Surgeon General that work has been performed upon the project or purchases have been made in accordance with the approved plans and specifications and that payment of an installment of federal funds is due the applicant.

History. Acts 1961, No. 414, § 17;
A.S.A. 1947, § 82-343.

20-9-211. Construction program — Federal funds.

(a) The State Board of Health is empowered to receive federal funds in behalf of, and transmit them to, such applicants.

(b) Money received from the United States Government for a construction project shall be deposited with the Treasurer of State as a trust fund designated the "Hospital and Medical Facilities Construction Fund". The fund shall be separate from all public funds of the state and shall be used solely for payments due applicants for work performed or purchases made in carrying out approved projects.

(c) Warrants for all payments from the fund shall bear the signature of the Director of the Department of Health or his or her agent.

(d) The procedure provided in this section for the receipt and disbursement of such funds is not intended to deprive any applicant from receiving federal payments directly if, for any reason, the Department of Health or the Treasurer of State is not authorized to receive and transmit federal payments for certain construction projects to certain applicants.

History. Acts 1961, No. 414, § 18; Medical Facilities Construction Fund, referred to in this section, no longer exists.
A.S.A. 1947, § 82-344.

Publisher's Notes. The Hospital and See title 19, chapters 5 and 6 of this code.

20-9-212. Minimum standards for hospitals and other institutions.

(a) The State Board of Health shall require hospitals and other institutions which receive federal aid for construction under the state plan to comply with such minimum standards prescribed by the Department of Health as may be promulgated in accordance with the federal act and federal rules and regulations.

(b) A hospital or institution, or the governing body thereof, shall comply with such minimum standards as may be prescribed by the department under the authority of this section even though federal aid may not be sought or received under this subchapter.

History. Acts 1961, No. 414, § 13;
A.S.A. 1947, § 82-339.

20-9-213. License required — Administration by State Board of Health.

(a) No hospital, recuperation center, or related institution shall be established, conducted, or maintained in this state without obtaining a license.

(b) The State Board of Health may provide, by properly promulgating rules and regulations, for the issuance of a recuperation center license.

(c) The Department of Health may provide, by properly promulgating rules and regulations, for the issuance of permanent type licenses, subject to revocation.

History. Acts 1961, No. 414, § 19;
1965, No. 434, § 1; 1971, No. 258, § 2;
A.S.A. 1947, § 82-345.

CASE NOTES

Breach of Contract Action.

Submission of the defective design for medical facility on November 27, 1987, and its rejection by the Health Department on December 4, 1987, constituted a material breach of contract since without

approved plans the facility would not be licensed and, without licensure the ambulatory surgery center could not operate. *Zufari v. Architecture Plus*, 323 Ark. 411, 914 S.W.2d 756 (1996).

20-9-214. Issuance of license — Fees.

(a) The State Board of Health shall issue licenses for the operation of institutions, subject to this subchapter, when the institutions are found to comply with the provisions of this subchapter and such regulations as are lawfully promulgated by the Department of Health.

(b) The Department of Health may levy and collect the following annual fees for issuance of an annual license to hospitals or institutions:

	Per facility (unless otherwise noted)	FY '98	FY '99
(1)	Hospitals (per bed)	\$ 4.00	\$ 6.00
(2)	Ambulatory Surgery Center	1,000.00	1,000.00
(3)	Hospital-Based Recuperation Center	160.00	275.00
(4)	Freestanding Recuperation Center	2,000.00	2,000.00
(5)	Hospital-Based Alcohol/Drug Unit	60.00	75.00
(6)	Freestanding Alcohol/Drug Unit	1,000.00	1,000.00
(7)	Hospital-Based Outpatient Psychiatric Center	60.00	75.00
(8)	Freestanding Outpatient Psychiatric Center	1,000.00	1,000.00
(9)	Infirmary	100.00	100.00
(10)	Reissuance of license due to name/address change	100.00	100.00

(c)(1) Applicants for license shall file applications under oath with the department upon forms prescribed by the department and shall pay an annual license fee as set forth in subsection (b) of this section, which shall be paid into the State Treasury or refunded to the applicant if a license is denied.

(2)(A) The application shall be signed by the owner, if an individual or partnership, in the case of a corporation by two (2) of its officers, or in the case of a governmental unit by the head of the governmental department having jurisdiction over it.

(B) Applications shall set forth the full name and address of the institution for which the license is sought and such additional information as the department may require, including affirmative evidence of ability to comply with such reasonable standards, rules, and regulations as may be lawfully prescribed in this subchapter.

(3) Applications for annual license renewal shall be postmarked no later than January 2 of the succeeding calendar year. License applications for existing institutions received after January 2 shall be subject to a penalty of one dollar (\$1.00) per day for each day after January 2.

(d)(1) Licenses issued under this section shall be effective on a calendar-year basis and shall expire on December 31 of each calendar year.

(2) A license shall be issued only for the premises and persons in the application and shall not be transferable.

(3) Licenses shall be posted in a conspicuous place on the licensed premises.

(e) All fees levied and collected under this chapter are special revenues and shall be deposited into the State Treasury, there to be credited to the Public Health Fund.

(f) Subject to such rules and regulations as may be implemented by the Chief Fiscal Officer of the State, the disbursing officer for the Department of Health may transfer all unexpended funds relative to the health facility services that pertain to fees collected, as certified by the Chief Fiscal Officer of the State, to be carried forward and made available for expenditures for the same purpose for any following fiscal year.

History. Acts 1961, No. 414, § 22; 1965, No. 454, § 2; A.S.A. 1947, § 82-348; Acts 1987, No. 143, §§ 2, 4; 1997, No. 574, § 1.

Cross References. Health Facility Services Revolving Fund, § 19-5-1089.

20-9-215. License — Denial, suspension, and revocation.

(a) The State Board of Health is empowered to deny, suspend, or revoke licenses on any of the following grounds:

(1) Violation of any of the provisions of this subchapter or the rules and regulations lawfully promulgated under this subchapter; or

(2) Permitting, aiding, or abetting the commission of any unlawful act in connection with the operation of the institutions.

(b)(1) If the Department of Health determines to deny, suspend, or revoke a license, it shall send to the applicant or licensee, by certified mail, a notice setting forth the particular reasons for the determination.

(2) The denial, suspension, or revocation shall become final thirty (30) days after the mailing of the notice unless the applicant or licensee gives written notice within the thirty-day period of a desire for hearing.

(c) Thereupon, the applicant or licensee shall be given a fair hearing and shall have the right to present such evidence as may be proper.

(d)(1) On the basis of the evidence at the hearing, the determination involved shall be affirmed or set aside.

(2) A copy of the decision, setting forth the finding of facts and the particular grounds upon which it is based, shall be sent by certified mail to the applicant or licensee.

(3) The decision shall become final fifteen (15) days after it is mailed unless the applicant or licensee, within the fifteen-day period, appeals the decision to the court under § 20-9-216.

(e) A full and complete record of all proceedings shall be kept and all testimony shall be reported, but it need not be transcribed unless the decision is appealed pursuant to § 20-9-216 or a transcript is requested by an interested party who shall pay the cost of preparing the transcript.

(f) Witnesses may be subpoenaed by either party and shall be allowed fees at a rate prescribed by regulations.

(g) The procedure governing hearings authorized by this section shall be in accordance with regulations promulgated by the department.

History. Acts 1961, No. 414, § 22;
1965, No. 454, § 2; A.S.A. 1947, § 82-348.

20-9-216. License — Judicial review.

(a) Any applicant or licensee who is dissatisfied with the decision of the State Board of Health or other body designated by the Department of Health or this subchapter as a result of the hearing provided in § 20-9-215 may appeal to the Pulaski County Circuit Court for judicial review of the decision within fifteen (15) days after receiving notice of the decision.

(b) Thereupon, the department shall promptly certify and file in court the transcript of the hearing on which the decision is based.

(c) Findings of fact by the department shall be conclusive unless contrary to law on the evidence.

(d) If necessary, the court may remand the case to the department to take further evidence, and the department may thereupon make new or modified findings of fact which shall have like weight on review.

(e) The court may affirm, modify, or reverse the decision of the department, and either the applicant or licensee or the department may appeal from the court's decision in the manner provided by law with regard to appeals from the court.

(f) Pending final disposition of the matter, the status quo of the applicant or licensee shall be preserved.

History. Acts 1961, No. 414, § 25;
A.S.A. 1947, § 82-351.

20-9-217. Alterations, additions, and new construction of facilities.

(a) The State Board of Health shall prescribe by regulation that any licensee or applicant desiring to make specified types of alterations or additions to its facilities or to construct new facilities, before commencing the alterations, additions, or new construction, shall submit plans and specifications for them to the Department of Health for preliminary

inspection and approval or recommendations with respect to compliance with the regulations and standards.

(b) From time to time, the Director of the Department of Health or his or her agent shall inspect each construction project approved by the United States Surgeon General. If the inspection so warrants, the director or his or her agent shall certify to the United States Surgeon General that work has been performed upon the project, or purchases have been made, in accordance with the approved plans and specifications, and that payment of an installment of federal funds is due the applicant.

History. Acts 1961, No. 414, § 21; A.S.A. 1947, § 82-347; Acts 1987, No. 143, § 3, is also codified as § 20-10-225.
Publisher's Notes. Acts 1987, No. 143, § 3, is also codified as § 20-10-225.

20-9-218. Emergency services facilities.

(a) The Department of Health is empowered to license under this subchapter and §§ 20-10-213 — 20-10-231 those hospitals which have discontinued inpatient services to continue to provide emergency services.

(b) The emergency services facilities shall be subject to inspection and to all other provisions of this subchapter and §§ 20-10-213 — 20-10-231 and all regulations promulgated under this subchapter and §§ 20-10-213 — 20-10-231.

(c) Hospital emergency services facilities licensed under this section shall not be required to obtain a certificate of need or any other permit other than that prescribed by this section.

History. Acts 1987, No. 516, § 1. centers, was repealed by Acts 1987, No. 593, § 10. The section was derived from Acts 1985, No. 980, § 3; A.S.A. 1947, § 82-345.1.
Publisher's Notes. Former § 20-9-218, concerning certificate of need and licensing of alcohol/drug abuse treatment

20-9-219. Inspections of facilities — Definitions.

(a) As used in this section:

(1) "Accrediting organization" means an organization that awards accreditation or certification to hospitals or managed care organizations and has been recognized by the Centers for Medicare & Medicaid Services for deemed status, including without limitation The Joint Commission;

(2)(A) "Hospital" means a facility used for the purpose of providing inpatient diagnostic care or treatment, including general medical care, surgical care, obstetrical care, psychiatric care, and specialized services or specialized treatment that is subject to the rules and regulations for hospitals in Arkansas.

(B) "Hospital" does not mean a facility primarily for the provision of long-term care;

(3) "Inspection" means the on-site review of the physical plant and practices as governed by the current rules and regulations of hospitals;

(4) "Investigation" means a specific inspection by the Division of Health Facilities Services related to a complaint or complaints; and

(5) "Survey" means the on-site formal review process of a hospital by the division at regular intervals to ensure compliance with applicable rules and regulations adopted by the Department of Health.

(b) The department shall make such inspections and surveys as it may prescribe by rule.

(c) Each hospital accredited by an accrediting organization shall be deemed by the department to be licensable without further survey by the personnel of the division if:

(1) The hospital holds current, full accreditation; and

(2) The division receives a copy of the hospital's official accreditation certificate and the complete report issued by an accrediting organization within thirty (30) days of receipt by the hospital from an accrediting organization.

(d) No hospital shall be required to submit accreditation by an accrediting organization, but whenever a hospital does not submit an accreditation certificate, the personnel of the department shall conduct such surveys as are prescribed by regulation.

(e)(1) Nothing in this section shall affect the right of an authorized representative of the department to enter upon or into the premises of a hospital at any time to make an inspection as part of an investigation when the department does so in response to a complaint or specific identifiable information that the hospital is not meeting minimum quality standards.

(2) If the division upon review of an accrediting organization report reasonably determines that a hospital may not be meeting state licensure standards, it may perform a survey of that hospital and take such steps as are necessary to enforce the standards of the department.

(f) A validation survey may be conducted on five percent (5%) of deemed hospitals during any calendar year to determine continued compliance with state regulations.

(g) The department shall continue to have authority over new construction, renovations, and alterations of the hospitals as set forth in the current regulations.

(h) All hospitals shall notify the division within thirty (30) days when there is a change in accreditation status.

(i) A staff member of the division may accompany an accrediting organization team that conducts any hospital accreditation survey as an ex officio member for the purpose of observation.

History. Acts 1961, No. 414, § 21; A.S.A. 1947, § 82-347; Acts 1999, No. 506, § 2; 2007, No. 136, § 1.

Publisher's Notes. Acts 1999, No. 506, § 1, provided: "Findings. The General Assembly of the State of Arkansas hereby finds and declares that the citizens of Arkansas are entitled to receive health care in hospitals which have been sur-

veyed on a regular basis to ensure high quality care, that a hospital must undergo two (2) duplicate surveys when they decide to become accredited by the Joint Commission on Accreditation of Healthcare Organizations, and that this duplication is costly and without effect on the quality of hospital care whenever a hospital, after survey, is accredited by the Joint

Commission on Accreditation of Health-care Organizations.”

20-9-220. Annual report.

The Department of Health shall make an annual report of its activities and operations under this subchapter to the Governor and shall make such information available to the General Assembly as may be requested.

History. Acts 1961, No. 414, § 24; A.S.A. 1947, § 82-350.

20-9-221. Information confidential.

(a) Information received by the Department of Health through inspection, or otherwise, authorized under this subchapter, shall not be disclosed publicly in such manner as to identify individuals or institutions except in a proceeding involving the question of licensing or revocation of a license.

(b)(1) However, in the case of a specific written request by the deputy director of the appropriate division as determined by the Director of the Department of Human Services for information concerning a certain nursing home, information obtained during recent inspections of the home may be supplied in writing to the deputy director.

(2) This exception applies only to homes providing care for recipients of public welfare and is not to be construed as permitting the exchange of such information on all homes in the state but is specifically limited to those for which the deputy director of the appropriate division as determined by the director has specific complaints.

(3) These complaints shall be forwarded to the department along with the request for information from the deputy director.

(4) Information received by the deputy director in the manner prescribed by this section shall not be disclosed.

History. Acts 1961, No. 414, § 23; 1965, No. 434, § 2; A.S.A. 1947, § 82-349.

RESEARCH REFERENCES

Ark. L. Rev. Watkins, Access to Public Records Under the Arkansas Freedom of Information Act, 37 Ark. L. Rev. 741.

20-9-222. Certification fee.

The Department of Health may levy and collect a fee for the issuance of an annual certification to child health management services clinics. The certification fee for a child health management services clinic shall be an annual fee of one thousand dollars (\$1,000).

History. Acts 1997, No. 574, § 4.

A.C.R.C. Notes. References to "this subchapter" in §§ 20-9-201 — 20-9-221 may not apply to this section which was enacted subsequently.

References to "this chapter" in subchap-

ter 1, §§ 20-9-201 — 20-9-221 and subchapters 3 and 5-9 may not apply to this section which was enacted subsequently.

Cross References. Health Facility Services Revolving Fund, § 19-5-1089.

20-9-223. Medical office licensure.

A medical office owned and operated by a physician or more than one (1) physician may apply for licensure by the State Board of Health as an outpatient surgery center.

History. Acts 2013, No. 587, § 4.

SUBCHAPTER 3 — HOSPITALS, CLINICS, ETC. — MISCELLANEOUS PROVISIONS

SECTION.

- 20-9-301. Posting of room rates.
- 20-9-302. Abortion clinics, health centers, etc.
- 20-9-303. [Repealed.]
- 20-9-304. Use of records for medical research.
- 20-9-305. Annual reports — Nonprofit hospitals.
- 20-9-306. Annual reports — Public-supported hospitals.
- 20-9-307. Itemized statement for services, drugs, and supplies.

SECTION.

- 20-9-308. Advice by hospital employees to reviewing committees.
- 20-9-309. Emergency Medical Care Act — Definitions.
- 20-9-310. No liability for furnishing medical records or accessing information pursuant to subpoena or other legal obligation or authority.
- 20-9-311. Findings — Definitions.

Cross References. Good Samaritan law, § 17-95-101.

Hospital's duty to report physician misconduct, § 17-95-104.

Reproductive health information, § 20-16-401 et seq.

Effective Dates. Acts 1969, No. 198, § 5: Mar. 7, 1969. Emergency clause provided: "It being immediately necessary for the furtherance of medical research and education and the protection of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this Act shall take effect and be in full force from and after its passage and approval."

Acts 1975 (Extended Sess., 1976), No. 1231, § 3: Feb. 16, 1976. Emergency clause provided: "It is hereby found and determined by the General Assembly that the operation of public supported hospitals which serve the public is of great interest and concern to the citizens of the State; that since the operation and financial condition of such hospitals is of serious concern to the

public, it is appropriate that such hospitals be required to publish an annual financial report, and that this Act should be given effect immediately in order to assure the publication of such reports at the earliest possible date. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1983, No. 509, § 4: Mar. 17, 1983. Emergency clause provided: "It is hereby found and determined by the General Assembly that there exists in the State facilities which are primarily abortion clinics; that the wilful termination or abortion of the pregnancy of a woman who is known to be pregnant is a hazardous procedure; that under present laws, such abortion clinics are not adequately supervised and regulated; that this Act is designed to provide for such supervision and regulation and should be given effect im-

mediately. Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1995, No. 1358, § 8: became law without the Governor's signature. Noted Apr. 17, 1995. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that there is an immediate and urgent need to protect the lives, health, and welfare of the people of Arkansas during medical emergencies which require these provisions to be authorized immediately. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Acts 2001, No. 451, § 5: June 1, 2001. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that numerous health care workers are presently exposed through the use of needles to bloodborne pathogens, serious viruses and diseases, including the human immunodeficiency virus (HIV), hepatitis B, and hepatitis C, and other potentially fatal diseases. The needleless systems or sharps with engi-

neered sharps injury protections required under this act will provide significant protections to the lives and health of health care workers. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on June 1, 2001."

Acts 2006 (1st Ex. Sess.), No. 4, § 11: Apr. 7, 2006. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the need to register sex offenders and update the registration files of sex offenders is necessary to ensure the safety of the citizens of the State of Arkansas; that the provisions of this act will improve the process of registering sex offenders and updating the registration files of sex offenders; and that this act is immediately necessary because of the public risk posed by sex offenders. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

Acts 2011, No. 1176, § 2: Jan. 1, 2012.

RESEARCH REFERENCES

ALR. Liability in tort for interference with physician's contract or relationship with hospital. 7 A.L.R.4th 572.

Hospital's liability for patient's injury or death as result of fall from bed. 9 A.L.R.4th 149.

Hospital's liability for patient's injury or death resulting from escape or at-

tempted escape. 37 A.L.R.4th 200.

Liability of hospital or clinic for sexual relationships with patients by staff physicians, psychologists, and other healers. 45 A.L.R.4th 289.

20-9-301. Posting of room rates.

(a) All public and private hospitals located and operated in this state shall post in some conspicuous place in each patient's room the daily room rates for both a private and a semiprivate room.

(b) Any hospital or person violating subsection (a) of this section shall be guilty of a violation and upon conviction shall be subject to a fine of not less than ten dollars (\$10.00) nor more than fifty dollars (\$50.00) for each violation.

History. Acts 1967, No. 91, §§ 1, 2; A.S.A. 1947, §§ 82-355, 82-356; Acts 2005, No. 1994, § 105.

20-9-302. Abortion clinics, health centers, etc.

(a)(1) A clinic, health center, or other facility in which the pregnancies of ten (10) or more women known to be pregnant are willfully terminated or aborted in any month, including nonsurgical abortions, shall be licensed by the Department of Health.

(2)(A) The department shall inspect a clinic, health center, or other facility at least annually, and inspections shall include without limitation:

(i) The facilities, equipment, and conditions of a clinic, health center, or other facility; and

(ii) A representative sample of procedures, techniques, medical records, informed consent signatures, and parental consent signatures.

(B) An inspector shall arrive at the clinic, health center, or other facility unannounced and without prior notice.

(b) The department shall:

(1) Adopt appropriate rules, regarding without limitation the facilities, equipment, procedures, techniques, medical records, informed consent signatures, parental consent signatures, and conditions of clinics, health centers, and other facilities subject to the provisions of this section to assure at a minimum that:

(A) The facilities, equipment, procedures, techniques, and conditions are aseptic and do not constitute a health hazard; and

(B) The medical records, informed consent signatures, and parental consent signatures meet statutory requirements;

(2) Levy and collect an annual fee of five hundred dollars (\$500) per facility for issuance of a permanent license to an abortion facility; and

(3)(A) Deny, suspend, or revoke licenses on any of the following grounds:

(i) The violation of any provision of law or rule; or

(ii) The permitting, aiding, or abetting of the commission of any unlawful act in connection with the operation of the institutions.

(B)(i) If the department determines to deny, suspend, or revoke a license, the department shall send to the applicant or licensee, by certified mail, a notice setting forth the particular reasons for the determination.

(ii) The denial, suspension, or revocation shall become final thirty (30) days after the mailing of the notice unless the applicant or licensee gives written notice within the thirty-day period of a desire for hearing.

(iii)(a) The department shall issue an immediate suspension of a license if an investigation or survey determines that:

(1) The applicant or licensee is in violation of any state law, rule, or regulation; and

(2) The violation or violations pose an imminent threat to the health, welfare, or safety of a patient.

(b)(1) The department shall give the applicant or licensee written notice of the immediate suspension.

(2) The suspension of the license is effective upon the receipt of the written notice.

(iv) The denial, suspension, or revocation order shall remain in effect until all violations have been corrected.

(C) The applicant or licensee shall:

(i) Be given a fair hearing; and

(ii) Have the right to present evidence as may be proper.

(D)(i) On the basis of the evidence at the hearing, the determination involved shall be affirmed or set aside.

(ii) A copy of the decision, setting forth the finding of facts and the particular grounds upon which it is based, shall be sent by certified mail to the applicant or licensee.

(iii) The decision shall become final fifteen (15) days after it is mailed unless the applicant or licensee, within the fifteen-day period, appeals the decision to the court.

(E) A full and complete record of all proceedings shall be kept and all testimony shall be reported, but it need not be transcribed unless the decision is appealed or a transcript is requested by an interested party who shall pay the cost of preparing the transcript.

(F) Witnesses may be subpoenaed by either party and shall be allowed fees at a rate prescribed by rule.

(G) The procedure governing hearings authorized by this section shall be in accordance with rules promulgated by the department.

(c)(1) Applicants for a license shall file applications upon such forms as are prescribed by the department.

(2) A license shall be issued only for the premises and persons in the application and shall not be transferable.

(d)(1) A license shall be effective on a calendar-year basis and shall expire on December 31 of each calendar year.

(2) Applications for annual license renewal shall be postmarked no later than January 2 of the succeeding calendar year.

(3) License applications for existing institutions received after that date shall be subject to a penalty of two dollars (\$2.00) per day for each day after January 2.

(e) Subject to such rules and regulations as may be implemented by the Chief Fiscal Officer of the State, the disbursing officer for the department may transfer all unexpended funds relative to the abortion clinics that pertain to fees collected, as certified by the Chief Fiscal Officer of the State, to be carried forward and made available for expenditures for the same purpose for any following fiscal year.

(f) All fees levied and collected under this section are special revenues and shall be deposited into the State Treasury to be credited to the Public Health Fund.

History. Acts 1983, No. 509, §§ 1, 2; A.S.A. 1947, §§ 82-367, 82-368; Acts 1987, No. 144, § 1; 2011, No. 1176, § 1; 2017, No. 383, § 2.

Amendments. The 2017 amendment substituted “in any” for “each” in (a)(1); rewrote (a)(2); rewrote former (b) as the introductory language of (b) and (b)(1); added (b)(2) and (b)(3); deleted former (c)

and redesignated the remaining subsections accordingly; and deleted “there” preceding “to be credited” in (f).

Cross References. Disposition of fetus or fetal material resulting from an abortion, §§ 20-17-801, 20-17-802.

Regulation of abortions, §§ 5-61-101, 20-16-601.

RESEARCH REFERENCES

ALR. Validity of State Statutes Requiring Abortion Clinic Physicians to Have Admitting Privileges at Local Hospital, and Abortion Clinics to Meet Requirements of, or Otherwise Comply with Stat-

utes Regarding, Ambulatory Surgical Centers. 3 A.L.R.7th 1 (2015).

U. Ark. Little Rock L.J. Legislative Survey, Health Law, 8 U. Ark. Little Rock L.J. 583.

20-9-303. [Repealed.]

Publisher’s Notes. This section, concerning medical treatment for sexual assault victims, was repealed by Acts 2001, No. 993, § 6. The section was derived

from Acts 1985, No. 400, §§ 1, 2; 1985, No. 838, §§ 1, 2; A.S.A. 1947, §§ 41-1828, 41-1829; Acts 1991, No. 612, § 4; 1993, No. 403, § 12.

20-9-304. Use of records for medical research.

(a) All information, interviews, reports, statements, memoranda, or other data of the State Board of Health, the Arkansas Medical Society, allied medical societies, or in-hospital staff committees of licensed hospitals, but not the original medical records pertaining to the patients, used in the course of medical studies for the purpose of reducing morbidity or mortality, as provided in this section, shall be strictly confidential and shall be used only for medical research.

(b) Any authorized person, hospital, sanatorium, nursing home, rest home, or other organization may provide information, interviews, reports, statements, memoranda, or other data relating to the condition and treatment of any person to any of the following for use in the course of studies for the purpose of reducing morbidity or mortality:

(1) The board;

(2) The Arkansas Medical Society or any committee or allied society thereof;

(3) Any other national medical organization approved by the board or any committee or allied medical society therein; or

(4) Any in-hospital staff committee of licensed hospitals.

(c) No liability for damages or other relief shall arise or be enforced against any authorized person, institution, or organization for:

(1) Providing the information or material;

(2) Releasing or publishing the findings and conclusions of the groups to advance medical research and medical education; or

(3) Releasing or publishing generally a summary of the studies.

(d)(1) The identity of the person whose condition or treatment has been studied shall be confidential and shall not be revealed under any circumstances.

(2) Any information furnished shall not contain the name of the person upon whom information is furnished and shall not violate the confidential relationship of patient and doctor.

(e)(1) Except for the original medical records pertaining to the patient, all information, interviews, reports, statements, memoranda, or other data furnished under this section and any findings or conclusions resulting from the studies are declared to be privileged communications that may not be used or offered or received in evidence in any legal proceeding of any kind.

(2) Except for the original medical records pertaining to the patient, any attempt to use or offer the information, interviews, reports, statements, memoranda or other data, findings, or conclusions, or any part thereof, shall constitute prejudicial error in any proceeding unless waived by the interested parties.

(f)(1) Physicians and others appointed to hospital utilization review committees for the purpose of determining the optimum use of hospital services shall be immune from liability with respect to decisions made as to utilization and actions thereunder so long as the physicians or others act in good faith.

(2) However, nothing in this section shall be construed to relieve any patient's personal physician of any liability which he or she may have in connection with the treatment of the patient.

(g) Nothing in this section shall be construed to prevent any court from subpoenaing the medical records of any patient.

History. Acts 1969, No. 198, §§ 1, 2;
A.S.A. 1947, §§ 82-357, 82-358.

RESEARCH REFERENCES

Ark. L. Rev. Watkins, Access to Public Records Under the Arkansas Freedom of Information Act, 37 Ark. L. Rev. 741.

20-9-305. Annual reports — Nonprofit hospitals.

(a)(1) Any nonprofit hospital association or corporation organized under the laws of this state that operates and maintains a hospital facility in this state primarily for providing hospital services for the employees of any corporation or company engaged in interstate commerce shall file annually with the Director of the Department of Finance and Administration a detailed report of income, fees, charges, and contributions from all sources received by it during the year, together with the expenses and disbursements of the corporation or association during the year.

(2) The report shall be filed on or before April 1 in each year.

(3) A copy of the report shall be furnished to each member of the hospital association or corporation upon the request of any member.

(b) Any nonprofit hospital association or corporation failing or refusing to file the report as required in subsection (a) of this section or which fails or refuses to furnish any member a copy of the report or statement upon request shall be guilty of a violation and shall be subject to a fine of ten dollars (\$10.00) for each day that the violation continues.

(c)(1) The provisions of this section shall not apply to any nonprofit hospital association or corporation that operates and maintains a hospital facility in any county of this state having a population of not less than twenty-five thousand six hundred (25,600) nor more than twenty-five thousand seven hundred (25,700), according to the 1970 Federal Decennial Census.

(2) The provisions of this section shall not be applicable with respect to any nonprofit hospital associations or corporations that operate and maintain a hospital facility in any county of this state having a population of not less than forty-seven thousand (47,000) nor more than fifty thousand (50,000), according to the 1970 Federal Decennial Census.

History. Acts 1971, No. 452, §§ 1-3; A.S.A. 1947, §§ 82-360 — 82-362; Acts 2005, No. 1994, § 106.

20-9-306. Annual reports — Public-supported hospitals.

(a) All public-supported hospitals in the State of Arkansas shall publish an annual report including financial statements showing profits, expenditures, and operating costs.

(b) Every such hospital shall publish its annual report in a newspaper of general circulation within the county where it is located.

History. Acts 1975 (Extended Sess., 1976), No. 1231, §§ 1, 2; A.S.A. 1947, §§ 82-365, 82-366; reen. Acts 1987, No. 1016, §§ 1, 2.

A.C.R.C. Notes. This section was reenacted by Acts 1987, No. 1016, §§ 1, 2. Acts

1987, No. 834, provided that 1987 legislation reenacting acts passed in the 1976 Extended Session should not repeal any other 1987 legislation and that such other legislation would be controlling in the event of conflict.

20-9-307. Itemized statement for services, drugs, and supplies.

(a)(1) Upon the patient's request at the time of discharge of each patient or at the time of billing the patient or the insurance company for the patient or at the time of billing the patient or the insurance company for the hospital services, drugs, and supplies, each hospital in the state, except those operated by the State of Arkansas, shall furnish to the patient and to the insurance company an itemized listing of all services, drugs, and supplies to be billed to that person while a patient in the hospital.

(2) The itemized statement shall be furnished to the patient and the insurance company no later than thirty (30) days after discharge of the patient.

(3) In addition, at the time of discharge each patient discharged from a hospital in this state shall be advised in writing of his or her right to receive the itemized statement for services, drugs, and supplies required by this section.

(4) The State Board of Health shall adopt rules specifying the items to be included and the manner in which they shall be presented on itemized statements as required in this section.

(b) The administrator or the agent of any hospital who fails or refuses to provide the itemized statement upon request as required in this section or fails or refuses at the time of discharge of any patient to advise the patient of his or her right to receive the itemized statement provided in this section shall be guilty of a violation and upon conviction shall be subject to a fine of not less than fifty dollars (\$50.00) nor more than one hundred fifty dollars (\$150) for each violation.

History. Acts 1987, No. 348, §§ 1-3;
Acts 2005, No. 1994, § 107.

20-9-308. Advice by hospital employees to reviewing committees.

When requested, any physician, surgeon, hospital administrator, nurse, technologist, and any other person engaged in work in or about a licensed hospital and having any information or knowledge relating to the medical and hospital care provided in the hospital or to the efficient use of the hospital facilities shall be obligated to advise committees reviewing such matters with respect to all the facts or information possessed by the individual with reference to such care or use.

History. Acts 1977, No. 445, § 2; A.S.A.
1947, § 19-4724.

CASE NOTES

Cited: Baxter County Newspapers,
Inc. v. Medical Staff of Baxter Gen. Hosp.,
273 Ark. 511, 622 S.W.2d 495 (1981).

20-9-309. Emergency Medical Care Act — Definitions.

(a) This section may be cited as the “Emergency Medical Care Act”.

(b) Because of the need for rapid assessment and care, in order to protect the life and health of the people of Arkansas during a medical emergency, it is found and declared necessary:

(1) To establish a definition for emergency medical care;

(2) To ensure that emergency medical care is provided in a timely manner by licensed and qualified personnel at a hospital’s emergency department; and

(3) To ensure that emergency medical care is not delayed or denied based on:

(A) A person's ability to pay for expenses incurred during a medical emergency; or

(B) Prospective authorization of treatment by an insurance company, health maintenance organization, hospital medical service corporation, health benefit plan, or any other insurer.

(c) As used in this section:

(1) "Emergency medical care" means healthcare services provided in a hospital emergency facility to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

(A) Placing the patient's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part;

(2) "Emergency medical provider" means a hospital licensed by the Department of Health, hospital-based services or a physician licensed by the Arkansas State Medical Board who provides emergency medical care; and

(3) "Prospective authorization" means contacting any insurer, health maintenance organization, hospital medical service corporation, or health benefit plan that is not physically present in the hospital's emergency department at the time the patient presents for emergency medical care for approval or authorization to evaluate and treat the patient.

(d)(1) Once a person qualifying for emergency medical care presents to an emergency department, that person shall be evaluated by medical personnel. This evaluation may include diagnostic testing to assess the extent of the condition, sickness, or injury and radiographic procedures and interpretations by a radiologist.

(2) Appropriate intervention may be initiated by medical personnel to stabilize any condition presenting under this section before receiving authorization for the treatment by an insurer, health maintenance organization, hospital medical service corporation, or health benefit plan.

History. Acts 1995, No. 1358, §§ 1-4.

20-9-310. No liability for furnishing medical records or accessing information pursuant to subpoena or other legal obligation or authority.

Notwithstanding any other law to the contrary, no person or medical facility serving as a custodian of health or medical records shall be subject to any civil or criminal liability for:

(1) Providing access to or producing copies of the records pursuant to a subpoena issued by any board, agency, commission, prosecuting attorney, or grand jury;

(2) Providing access to or producing a copy of the health or medical records requested by a clerk of a court, the Department of Correction, the Department of Community Correction, the Arkansas State Hospital, the Department of Health, the Department of Human Services, or a local law enforcement agency under the Sex Offender Registration Act of 1997, § 12-12-901 et seq.; or

(3) Requesting or accessing information under § 17-80-116.

History. Acts 1999, No. 1536, § 12;
2006 (1st Ex. Sess.), No. 4, § 10.

20-9-311. Findings — Definitions.

(a) The General Assembly finds that:

(1) Numerous workers who are occupationally exposed to blood-borne pathogens have contracted fatal and other serious viruses and diseases, including the human immunodeficiency virus (HIV), hepatitis B, and hepatitis C, from exposure to blood and other potentially infectious materials in their workplaces;

(2) In 1991, the United States Occupational Safety and Health Administration issued a standard regulating occupational exposure to blood-borne pathogens including the human immunodeficiency virus (HIV), the hepatitis B virus, and the hepatitis C virus;

(3) Compliance with the blood-borne pathogens standard has significantly reduced the risk that workers will contract a blood-borne disease in the course of their work;

(4) Nevertheless, occupational exposure to blood-borne pathogens from accidental sharps injuries in healthcare settings continues to be a serious problem;

(5) In March 2000, the Centers for Disease Control and Prevention estimated that more than three hundred eighty thousand (380,000) percutaneous injuries from contaminated sharps occur annually among healthcare workers in United States hospital settings;

(6) Estimates for all healthcare settings are that six hundred thousand (600,000) to eight hundred thousand (800,000) needlestick and other percutaneous injuries occur among healthcare workers annually involving sharps contaminated with blood-borne pathogens such as the human immunodeficiency virus (HIV), hepatitis B, or hepatitis C;

(7) Since publication of the blood-borne pathogens standard in 1991, there has been a substantial increase in the number and assortment of effective engineering controls available to employers;

(8) There is now a large body of research and data concerning the effectiveness of newer engineering controls, including safer medical devices;

(9) Numerous studies have demonstrated that the use of safer medical devices such as needle-less systems and sharps with engi-

neered sharps injury protections can be extremely effective in reducing accidental sharps injuries when they are part of an overall blood-borne pathogens risk-reduction program;

(10) In March 2000, the Centers for Disease Control and Prevention estimated that sixty-two percent (62%) to eighty-eight percent (88%) of sharps injuries potentially can be prevented by the use of safer medical devices depending on the type of device used and the procedure involved;

(11) Training and education in the use of safer medical devices and safer work practices are significant elements in the prevention of percutaneous exposure incidents;

(12) Staff involvement in the device selection and evaluation process is also an important element in achieving a reduction in sharps injuries, particularly as newer, safer devices are introduced into work settings;

(13) The United States Congress has recognized the seriousness of the dangers of sharps injuries by passing the Needlestick Safety and Prevention Act, Pub. L. No. 106-430; and

(14) Considerable time will lapse before federal regulations are published, hospitals prepare implementation plans, federal agencies review implementation plans, and hospitals begin implementation.

(b) As used in this section:

(1) "High-risk area" means the emergency department, operating rooms, and intensive care units in acute care hospitals;

(2) "Needleless systems" means devices that do not use needles for:

(A) The collection of bodily fluids or withdrawal of bodily fluids after initial venous or arterial access is established;

(B) The administration of medication or fluids; or

(C) Any other procedure involving the potential for occupational exposure to blood-borne pathogens due to percutaneous injuries from contaminated sharps;

(3) "Sharps" means a needle used to withdraw bodily fluids, access a vein or artery, or administer medication or other fluids; and

(4) "Sharps with engineered sharps injury protections" means a nonneedle sharp or a needle device used for withdrawing bodily fluids, accessing a vein or artery, or administering medications or other fluids with a built-in safety feature or mechanism that effectively reduces the risk of an exposure incident.

(c) Immediately after June 1, 2001, hospitals shall begin purchasing needleless systems or sharps with engineered sharps injury protections, or both, for use in high-risk areas, with the goal of ensuring that within eighteen (18) months after June 1, 2001, all high-risk areas shall be supplied exclusively with needleless systems or sharps with engineered sharps injury protections, or both.

(d) Any prefilled syringe approved by the United States Food and Drug Administration shall not be subject to the provisions of this section until July 2005.

History. Acts 2001, No. 451, §§ 1-4.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of assembly, Public Health and Welfare, 24 U. Legislation, 2001 Arkansas General As- Ark. Little Rock L. Rev. 557.

SUBCHAPTER 4 — FREESTANDING BIRTHING CENTERS

SECTION.
20-9-401. Definitions.
20-9-402. Deliveries — Dismissal of mother and infant.
20-9-403. Regulation by Department of Health.

SECTION.
20-9-404. License fee.
20-9-405. Practice of midwifery.

A.C.R.C. Notes. References to “this chapter” in subchapters 1-3 or 5-9 may not apply to this subchapter which was enacted subsequently.
Publisher’s Notes. Former subchapter 4, dealing with the State Medical Services Advisory Commission, was repealed by Acts 1989, No. 536, § 7. The subchapter was derived from the following sources:

20-9-401. Acts 1965, No. 372, § 1; A.S.A. 1947, § 7-601.
20-9-402. Acts 1965, No. 372, § 2; A.S.A. 1947, § 7-602.
20-9-403. Acts 1965, No. 372, § 3; A.S.A. 1947, § 7-603.
20-9-404. Acts 1965, No. 372, § 4; A.S.A. 1947, § 7-604.

20-9-401. Definitions.

As used in this subchapter:

- (1) “Freestanding birthing center” means any facility, institution, or place, which is not an ambulatory surgical center or a hospital or in a hospital, organized to provide family-centered maternity care for women and childbearing families in which births are planned to occur in a homelike atmosphere away from the mothers’ usual residences following a low-risk pregnancy; and
- (2) “Low-risk pregnancy” means a normal uncomplicated pregnancy as determined by a generally accepted course of prenatal care and expectation of a normal uncomplicated birth as defined by reasonable and generally accepted criteria of maternal and fetal health.

History. Acts 1997, No. 891, § 1.

20-9-402. Deliveries — Dismissal of mother and infant.

- (a) A freestanding birthing center shall have a qualified medical director, and deliveries shall be performed by a qualified physician or by a certified nurse midwife in accordance with an arrangement with a physician as required by § 17-87-101 et seq.
- (b) A mother and her infant shall be dismissed from a freestanding birthing center within twenty-four (24) hours of the admission.

History. Acts 1997, No. 891, § 2.

20-9-403. Regulation by Department of Health.

(a) The Department of Health shall establish and enforce regulations:

(1) Setting minimum standards for the construction, maintenance, and operation of a freestanding birthing center; and

(2) Setting qualifications for medical directors of freestanding birthing centers and for physicians who will perform deliveries in freestanding birthing centers.

(b) A freestanding birthing center shall meet life safety code and construction standards developed by the National Fire Protection Association and shall comply with regulations developed by the department.

History. Acts 1997, No. 891, § 3.

20-9-404. License fee.

The Department of Health may levy and collect a fee for the issuance of an annual license to a freestanding birthing center. The license fee for a freestanding birthing center shall be an annual fee of one thousand dollars (\$1,000).

History. Acts 1997, No. 891, § 5.

20-9-405. Practice of midwifery.

Nothing in this subchapter shall be construed to prohibit the lawful practice of lay midwifery in any location under the Licensed Lay Midwife Act, § 17-85-101 et seq.

History. Acts 1997, No. 891, § 4.

SUBCHAPTER 5 — PEER REVIEW COMMITTEES**SECTION.**

20-9-501. Definition.

20-9-502. Liability of committee members.

SECTION.

20-9-503. Proceeding and records confidential — Exception.

Effective Dates. Acts 1975, No. 191, § 6: Feb. 18, 1975. Emergency clause provided: "It is hereby found and determined by the General Assembly that there is currently no law which grants specific immunity to the members of peer review committees as defined in Section 1 hereof and functioning in the State of Arkansas; that it is essential to the proper and effective operations of such committees that immunity be granted members of such committees for acts of the members

performed within the scope of the functions of the committee and without malice or fraud; that this Act is designed to grant such immunity only in actions by providers of health services against such committees or the members thereof; that it is urgent that this Act be given effect at the earliest possible date to grant this limited immunity to peer review committees in order that they may perform their functions and duties more effectively. Therefore, an emergency is hereby declared to

exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval.”

RESEARCH REFERENCES

ALR. Negligence in failing to review or supervise treatment given by doctor, or to require consultation. 12 A.L.R.4th 57. Disclosure of privileged proceedings of hospital medical review or doctor evaluation processes. 60 A.L.R.4th 1273. C.J.S. 41 C.J.S., Hospitals, §§ 16-18.

20-9-501. Definition.

As used in this subchapter, “peer review committee” or “committee” means a committee of a hospital medical staff, a committee of a state or local professional association, or a committee organized by and operating pursuant to a written plan or policy under the auspices of a professional corporation or a professional limited liability company whose members are licensed to practice medicine in this state that is formed to:

- (1) Evaluate and improve the quality of health care rendered by providers of health services; or
- (2) Determine that:

(A) Health services rendered were professionally indicated or were performed in compliance with the applicable standard of care; or

(B) The cost of health care rendered was considered reasonable by the providers of professional health services in the area.

History. Acts 1975, No. 191, § 1; A.S.A. 1947, § 82-3201; Acts 1999, No. 1536, § 9; 2013, No. 441, § 1. inserted “or a committee organized by and operating ... licensed to practice medicine in this state” in the introductory paragraph.

Amendments. The 2013 amendment

RESEARCH REFERENCES

Ark. L. Rev. J. Taylor White, Case Note: Paulino v. QHG of Springdale, Inc., and Negligent Credentialing: A Look into Peer-Review Statutes and the Health Care Quality Improvement Act, 66 Ark. L. Rev. 879 (2013).

CASE NOTES

Applicability. Arkansas Supreme Court declined to create a new tort for negligent credentialing of a physician; under subdivision (2)(A) of this section, a statutory system was in place for the initial and ongoing review of competency as part of the credentialing process to assure that health services were being performed in accordance with the appropriate standard of care. Paulino v. QHG of Springdale, Inc., 2012 Ark. 55, 386 S.W.3d 462 (2012).

20-9-502. Liability of committee members.

(a) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any member of a peer review committee for any act or proceeding undertaken or performed within the scope of the functions of the committee if the committee member acts without malice or fraud.

(b) This subchapter shall not be construed to confer immunity from liability on any professional association or upon any health professional while performing services other than as a member of a peer review committee.

History. Acts 1975, No. 191, §§ 2, 3; A.S.A. 1947, §§ 82-3202, 82-3203.

RESEARCH REFERENCES

Ark. L. Rev. J. Taylor White, Case Peer-Review Statutes and the Health Note: Paulino v. QHG of Springdale, Inc., Care Quality Improvement Act, 66 Ark. L. and Negligent Credentialing: A Look into Rev. 879 (2013).

20-9-503. Proceeding and records confidential — Exception.

(a)(1) The proceedings and records of a peer review committee shall not be subject to discovery or introduction into evidence in any civil action against a provider of professional health services arising out of the matters which are subject to evaluation and review by the committee.

(2) No person who was in attendance at a meeting of the committee shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or any members thereof.

(b)(1) However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such action merely because they were presented during the proceedings of the committee.

(2) Nor shall any person who testifies before the committee or who is a member of the committee be prevented from testifying as to matters within his or her knowledge, but the witness shall not be asked about his or her testimony before the committee or about opinions formed by him or her as a result of the committee hearings.

(c) The submission of the peer review proceedings, minutes, records, reports, and communications to a hospital governing board or physician group peer review committee as defined under § 20-9-501 shall not operate as a waiver of the privilege.

History. Acts 1975, No. 191, § 4; A.S.A. 1947, § 82-3204; Acts 1999, No. 1536, § 10; 2013, No. 441, § 2.

Amendments. The 2013 amendment inserted “or physician group peer review committee as defined under § 20-9-501”

in (c).

RESEARCH REFERENCES

Ark. L. Rev. J. Taylor White, Case Note: Paulino v. QHG of Springdale, Inc., and Negligent Credentialing: A Look into

Peer-Review Statutes and the Health Care Quality Improvement Act, 66 Ark. L. Rev. 879 (2013).

CASE NOTES

Revocation of Staff Privileges.

All records, documents, and other information provided to the state medical board regarding revocation of the medical staff privileges of defendant are absolutely privileged by Arkansas statutory

provisions and cannot be discovered or admitted into evidence in a medical malpractice suit. *Hendrickson v. Leipzig*, 715 F. Supp. 1443 (E.D. Ark. 1989).

Cited: *Saline Mem. Hosp. v. Berry*, 321 Ark. 588, 906 S.W.2d 297 (1995).

SUBCHAPTER 6 — CONSENT TO TREATMENT

SECTION.

20-9-601. Definition.

20-9-602. Consent generally — Definition.

SECTION.

20-9-603. Implied consent — Definition.

20-9-604. Consent given by court in emergency.

Effective Dates. Acts 1973, No. 328, § 5: Mar. 14, 1973. Emergency clause provided: “It is hereby found and determined by the General Assembly that at the present time a minor will not be allowed to undergo certain medical or surgical procedures without the consent of a parent or guardian and that the law is unclear as to the consent required before surgical or medical procedures can be performed on other individuals not capable of consent due to injury or incompetence, and that this present situation greatly impairs medical treatment and frequently endangers the life and limb of the patient when consent for medical and surgical treatment is unavailable and that in order to alleviate this problem it is necessary for this Act to become effective immediately. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval.”

Acts 1977, No. 805, § 5: Mar. 28, 1977. Emergency clause provided: “It is hereby found and determined by the General Assembly that there is confusion in the minds of many people as to when consent

to emergency medical treatment shall be implied under the law even though consent is apparently refused or withheld by one authorized to consent; that where a minor, adult of unsound mind, pregnant female or parent of a minor child is in dire need of emergency medical treatment, the State of Arkansas must consent to such treatment for the good of all when consent is withheld by one empowered or capable of consent; and that this Act should be given effect immediately to accomplish these purposes. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health, and safety shall be in full force and effect from and after its passage and approval.”

Acts 1981, No. 511, § 5: Mar. 16, 1981. Emergency clause provided: “It is hereby found and determined by the General Assembly that there is confusion in the minds of many people as to the circumstances in which a parent can consent for its child, natural, adopted, stepchild or foster child, and that a married person or aged person may not be allowed to undergo certain medical or surgical procedures without appropriate consent and that the law is unclear as to the consent

required before surgical or medical procedures can be performed, and that this present situation greatly impairs medical treatment and frequently endangers the life and limb of the patient when consent for medical and surgical treatment is unavailable and that in order to alleviate this problem it is necessary for this Act to

become effective immediately. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

RESEARCH REFERENCES

ALR. Consent of patient with mental disabilities. 8 A.L.R.4th 464.

Misrepresentation of the nature and hazards of treatment. 42 A.L.R.4th 543.

Medical practitioner's liability for treatment given child without parent's consent. 67 A.L.R.4th 511.

Nonconsensual treatment of involuntarily committed mentally ill persons with neuroleptic or antipsychotic drugs as violative of state constitutional guaranty. 74 A.L.R.4th 1099.

Am. Jur. 61 Am. Jur. 2d, Physicians, § 148 et seq.

Ark. L. Notes. Leflar, Advance Health Care Directives Under Arkansas Law, 1994 Ark. L. Notes 37.

Ark. L. Rev. Leflar, Liberty and Death: Advance Health Care Directives and the Law of Arkansas, 39 Ark. L. Rev. 375.

C.J.S. 70 C.J.S., Phys & S., § 136 et seq.

U. Ark. Little Rock L.J. On Teaching Law and Medicine, Spies, 1 U. Ark. Little Rock L.J. 412.

20-9-601. Definition.

(a) As used in this subchapter, "of unsound mind" means the inability to perceive all relevant facts related to one's condition and proposed treatment so as to make an intelligent decision based thereon, whether or not the inability is:

(1) Only temporary, has existed for an extended period of time, or occurs or has occurred only intermittently; or

(2) Due to natural state, age, shock or anxiety, illness, injury, drugs or sedation, intoxication, or other cause of whatever nature.

(b) An individual shall not be considered to be of unsound mind based solely upon his or her refusal of medical care or treatment.

History. Acts 1981, No. 511, § 2; A.S.A. 1947, § 82-363.1.

RESEARCH REFERENCES

U. Ark. Little Rock L.J. Legislative Survey, Miscellaneous, 4 U. Ark. Little Rock L.J. 605.

20-9-602. Consent generally — Definition.

It is recognized and established that, in addition to other authorized persons, any one (1) of the following persons may consent, either orally or otherwise, to any surgical or medical treatment or procedure not

prohibited by law that is suggested, recommended, prescribed, or directed by a licensed physician:

- (1) Any adult, for himself or herself;
- (2)(A) Any parent, whether an adult or a minor, for his or her minor child or for his or her adult child of unsound mind whether the child is of the parent's blood, an adopted child, a stepchild, a foster child not in custody of the Department of Human Services, or a preadoptive child not in custody of the Department of Human Services.
 - (B) However, the father of an illegitimate child cannot consent for the child solely on the basis of parenthood;
- (3) Any married person, whether an adult or a minor, for himself or herself;
- (4) Any female, regardless of age or marital status, for herself when given in connection with pregnancy or childbirth, except the unnatural interruption of a pregnancy;
- (5) Any person standing in loco parentis, whether formally serving or not, and any guardian, conservator, or custodian, for his or her ward or other charge under disability;
- (6) Any emancipated minor, for himself or herself;
- (7) Any unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures, for himself or herself;
- (8) Any adult, for his or her minor sibling or his or her adult sibling of unsound mind;
- (9) During the absence of a parent so authorized and empowered, any maternal grandparent and, if the father is so authorized and empowered, any paternal grandparent, for his or her minor grandchild or for his or her adult grandchild of unsound mind;
- (10) Any married person, for a spouse of unsound mind;
- (11) Any adult child, for his or her mother or father of unsound mind;
- (12) Any minor incarcerated in the Department of Correction or the Department of Community Correction, for himself or herself; and
- (13)(A) Any foster parent or preadoptive parent for a child in custody of the Department of Human Services in:

(i)(a) Emergency situations.

(b) As used in this subdivision (13)(A)(i), "emergency situation" means a situation in which, in competent medical judgment, the proposed surgical or medical treatment or procedures are immediately or imminently necessary and any delay occasioned by an attempt to obtain a consent would reasonably be expected to jeopardize the life, health, or safety of the person affected or would reasonably be expected to result in disfigurement or impaired faculties;

- (ii) Routine medical treatment;
- (iii) Ongoing medical treatment;
- (iv) Nonsurgical procedures by a primary care provider; and
- (v) Nonsurgical procedures by a specialty care provider.

(B) The Department of Human Services shall be given timely notice of all admissions and discharges consented to by a foster

parent or preadoptive parent for a child in custody of the Department of Human Services.

(C) The consent of a representative of the Department of Human Services is required for:

- (i) Nonemergency surgical procedures;
- (ii) Nonemergency invasive procedures;
- (iii) "End-of-life" nonemergency procedures, such as do-not-resuscitate orders, withdrawal of life support, and organ donation; and
- (iv) Nonemergency medical procedures relating to a criminal investigation or judicial proceeding that involves gathering forensic evidence.

History. Acts 1973, No. 328, § 1; 1981, 1995, No. 632, § 1; 1997, No. 875, § 1; No. 511, § 1; A.S.A. 1947, § 82-363; Acts 2009, No. 700, § 1.

RESEARCH REFERENCES

U. Ark. Little Rock L.J. Legislative Survey, Miscellaneous, 4 U. Ark. Little Rock L.J. 605.

CASE NOTES

Arbitration.

This section does not contemplate the signing of an arbitration agreement by an adult child on behalf of a parent of unsound mind. Therefore, in a case against a nursing home alleging negligence and other causes of action, a valid arbitration agreement was not shown because a de-

cedent's son did not have authority to bind the decedent to the arbitration agreement under this section. *Courtyard Gardens Health & Rehab., LLC v. Quarles*, 2013 Ark. 228, 428 S.W.3d 437 (2013).

Cited: *Neff v. St. Paul Fire & Marine Ins. Co.*, 304 Ark. 18, 799 S.W.2d 795 (1990).

20-9-603. Implied consent — Definition.

In addition to any other instances in which consent is excused or implied at law, consent to surgical or medical treatment or procedures suggested, recommended, prescribed, or directed by a licensed physician will be implied in the following circumstances:

(1)(A) When an emergency exists and there is no one immediately available who is authorized, empowered to, or capable of consent.

(B) "Emergency" means a situation in which, in competent medical judgment, the proposed surgical or medical treatment or procedures are immediately or imminently necessary and any delay occasioned by an attempt to obtain a consent would reasonably be expected to jeopardize the life, health, or safety of the person affected or would reasonably be expected to result in disfigurement or impaired faculties; and

(2) When any emergency exists, there has been a protest or refusal of consent by a person authorized and empowered to do so, and there is no other person immediately available who is authorized, empowered, or capable of consenting but there has been a subsequent material and morbid change in the condition of the affected person.

History. Acts 1973, No. 328, § 2; 1977, No. 805, § 1; A.S.A. 1947, § 82-364.

20-9-604. Consent given by court in emergency.

(a)(1) Except as provided in subsection (e) of this section, consent may be given by a court when:

(A) An emergency exists;

(B) There has been a protest or refusal of consent by a person authorized and empowered to do so; and

(C) There is no other person immediately available who is authorized, empowered, or capable of consent.

(2) The consent shall be given upon the presentation of a petition accompanied by the written advice or certificate of one (1) or more licensed physicians that in their professional opinion there is an immediate or imminent necessity for medical or surgical treatment or procedures.

(3) Any circuit judge may summarily grant injunctive and declaratory relief ordering and directing that the necessary surgical or medical treatment or procedures be rendered, provided that the affected person is:

(A) A pregnant female in the last trimester of pregnancy;

(B) A person of insufficient age or mental capacity to understand and appreciate the nature of the proposed surgical or medical treatment and the probable consequences of refusal of the treatment;
or

(C) A parent of a minor child, provided that the court in its discretion finds that the life or health of the parent is essential to the child's financial support or physical or emotional well-being.

(b) Any circuit judge granting the declaratory and injunctive relief directing the provision of surgical or medical treatment or procedures pursuant to this section shall be immune from liability based on any claim that the surgical or medical treatment or procedures for the affected person should not have been administered.

(c) The reasonable expense incurred for emergency surgical or medical treatment or procedures administered pursuant to this section shall be borne by:

(1) The estate of the person affected;

(2) Any person liable at law for the necessities of the person affected;
or

(3) If the estate or person is unable to pay, the county of residence of the person receiving the surgical or medical care.

(d) Upon request of an attending physician, any other licensed physician, or a representative of a hospital to which a patient has been admitted or presented for treatment, it shall be the duty of the prosecuting attorney, or his or her designee, of the county in which the surgical or medical care is proposed to be rendered to give his or her assistance in the presentation of the petition, with medical advice or certificate, and in obtaining an order from the court of proper jurisdiction.

(e)(1) Consent may be given by a court when an emergency exists and there is no one immediately available who is authorized, empowered to, or capable of consent for a person of unsound mind or there has been a subsequent material and morbid change in the condition of the affected person who is in the custody of the Department of Correction or the Department of Community Correction.

(2) The consent shall be given upon the presentation of a petition accompanied by the written advice or certificate of one (1) or more licensed physicians that in their professional opinion there is an immediate or imminent necessity for medical or surgical treatment or procedures.

(3) Any circuit judge may summarily grant injunctive and declaratory relief ordering and directing that the necessary surgical or medical treatment or procedures be rendered.

History. Acts 1977, No. 805, § 2; A.S.A. 1947, § 82-364.1; Acts 1997, No. 875, § 2.

SUBCHAPTER 7 — MEDICARE

SECTION.

20-9-701. Uniform Medicare charges.

20-9-702. Immunity of hospital utilization review committees.

Preambles. Acts 1973, No. 416, contained a preamble which read: "Whereas, the Medicare program, which is financed by taxpayer funds provides for payment to physicians for medical services rendered to Medicare patients; and

"Whereas, under the present system, payments to physicians are based on five localities resulting in reasonable charge prevailing limits in urban areas which are frequently higher than the prevailing limits in rural areas for similar services; and

"Whereas, the rural areas of the State are in dire need of additional physicians to meet the health needs of those areas, yet, we are discriminating against and discouraging physicians going to rural areas by providing lower prevailing limits of payment for services rendered by such physicians to Medicare patients; and

"Whereas, it is believed that since the Medicare program is financed by tax funds contributed to equally by the citi-

zens in all areas of the State, reasonable charge prevailing limits for physician's services under the program should be uniform in all areas of the State;

"Now, therefore ... "

Effective Dates. Acts 1969, No. 87, § 2: Feb. 21, 1969. Emergency clause provided: "It is hereby found and determined by the General Assembly that it is essential that physicians and others serving on hospital utilization review committees for the purpose of determining questions relative to the hospitalization of Medicare patients be given immunity from liability for decisions of judgment in the performance of their duties so long as such decisions are made in good faith, and that this Act is immediately necessary to provide such immunity. Therefore, an emergency is hereby declared to exist and this Act being immediately necessary for the preservation of the public peace, health and safety shall be in effect from the date of its passage and approval."

RESEARCH REFERENCES

ALR. Fraud in connection with claims under Medicaid, Medicare, or similar welfare programs for providing medical services. 32 A.L.R.4th 671.

Filing of false insurance claims for medical services as ground for disciplinary action against dentist, physician, or

other medical practitioner. 70 A.L.R.4th 132.

Am. Jur. 70C Am. Jur. 2d, Soc. Sec., § 1904 et seq.

C.J.S. 81 C.J.S., Soc. S. & P.W., § 232 et seq.

20-9-701. Uniform Medicare charges.

The agency administering the Medicare program in Arkansas shall establish reasonable charges on a single statewide basis according to field of practice. The reasonable charges shall be based on uniform prevailing limits for all physicians throughout the state for the same or similar services.

History. Acts 1973, No. 416, § 1; A.S.A. 1947, § 66-5101.

20-9-702. Immunity of hospital utilization review committees.

- (a) Physicians and others appointed to hospital utilization review committees for the purpose of determining questions relating to the hospitalization of Medicare patients under the Health Insurance for the Aged and Disabled Act, 42 U.S.C. § 1395 et seq., shall be immune from liability with respect to decisions made as to such questions as long as the physicians or others act in good faith and without malice.
- (b) However, nothing in this section shall be construed to relieve any patient's personal physician of any liability which he or she may have in connection with the treatment of the patient.

History. Acts 1969, No. 87, § 1; A.S.A. 1947, § 82-359.

SUBCHAPTER 8 — TRANSPLANTS

- SECTION.
- 20-9-801. Declaration of policy.
- 20-9-802. Limitation of liability.

Cross References. Revised Arkansas Anatomical Gift Act, 20-17-1201 et seq.

Effective Dates. Acts 1971, No. 462, § 3: Mar. 30, 1971. Emergency clause provided: "It having been found by the General Assembly that the transplantation and transfusion of human tissues is a necessary part of the protection of human health and life and that hospitals and

physicians are reluctant to perform these services under existing conditions and that the immediate passage of this act is necessary for the protection of the health, safety and welfare of the people of the State of Arkansas, an emergency is hereby declared to exist and this act shall take effect immediately upon its passage and approval."

RESEARCH REFERENCES

Ark. L. Notes. Copeland, A Statutory Do Its Rules Apply?, 1990 Ark. L. Notes
Primer: Article 2 of the U.C.C., — When 39.

20-9-801. Declaration of policy.

(a) The availability of scientific knowledge, skills, and materials for the transplantation, injection, transfusion, or transfer of human tissue, organs, blood, and components thereof is important to the health and welfare of the people of this state.

(b) The imposition of legal liability without fault upon the persons and organizations engaged in such scientific procedures inhibits the exercise of sound medical judgment and restricts the availability of important scientific knowledge, skills, and materials.

(c) It is therefore the public policy of this state to promote the health and welfare of the people by limiting the legal liability arising out of such scientific procedures to instances of negligence or willful misconduct.

History. Acts 1971, No. 462, § 1; A.S.A.
1947, § 82-1607.

CASE NOTES

Cited: Kirkendall v. Harbor Ins. Co.,
698 F. Supp. 768 (W.D. Ark. 1988).

20-9-802. Limitation of liability.

No physician, surgeon, hospital, blood bank, tissue bank, or other person or entity who donates, obtains, prepares, transplants, injects, transfuses, or otherwise transfers or who assists or participates in obtaining, preparing, transplanting, injecting, transfusing, or transferring any tissue, organ, blood, or component thereof from one (1) or more human beings, living or dead, to another human being, shall be liable as the result of the activity, except that each such person or entity shall remain liable for negligence or willful misconduct only.

History. Acts 1971, No. 462, § 2; A.S.A.
1947, § 82-1608.

CASE NOTES**Supplying of Blood.**

The supplying of blood for transfusions is a service rather than a product and the implied warranties of the Uniform Commercial Code do not apply to blood; further, blood is not a "product" for purposes

of imposing strict liability in tort. Kirkendall v. Harbor Ins. Co., 887 F.2d 857 (8th Cir. 1989).

Cited: Kirkendall v. Harbor Ins. Co.,
698 F. Supp. 768 (W.D. Ark. 1988).

SUBCHAPTER 9 — UTILIZATION REVIEW

SECTION.

- 20-9-901. Purpose.
- 20-9-902. Definitions.
- 20-9-903. Certificate required.
- 20-9-904. When certificate not required.
- 20-9-905. Penalty.
- 20-9-906. Duties of State Board of Health.
- 20-9-907. Health insurance plans — Insurers.
- 20-9-908. Application for certification — Fee.

SECTION.

- 20-9-909. Information required with application.
- 20-9-910. Expiration of certificate — Renewal.
- 20-9-911. Revocation or denial of certificate.
- 20-9-912. Appeals.
- 20-9-913. Confidentiality.
- 20-9-914. Liability unaffected.

Effective Dates. Acts 1989, No. 537, § 19: Jan. 1, 1990.

Acts 1993, No. 1045, § 5: Apr. 12, 1993. Emergency clause provided: "It is hereby found and determined by the General Assembly that a carry forward provision should apply to application fees in the utilization review program for the effective

administration of the program. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

20-9-901. Purpose.

The purpose of this subchapter is to:

- (1) Promote the delivery of quality health care in a cost-effective manner;
- (2) Foster greater coordination between payors and providers conducting utilization review activities;
- (3) Protect patients, business, and providers by ensuring that private review agents are qualified to perform utilization activities and to make informed decisions on the appropriateness of medical care; and
- (4) Ensure that private review agents maintain the confidentiality of medical records.

History. Acts 1989, No. 537, § 2.

20-9-902. Definitions.

As used in this subchapter:

- (1) "Board" means the State Board of Health;
- (2) "Certificate" means a certificate of registration granted by the board to a private review agent;
- (3)(A) "Private review agent" means a nonhospital-affiliated person or entity performing utilization review on behalf of:
 - (i) An employer of employees in the State of Arkansas; or
 - (ii) A third party that provides or administers hospital and medical benefits to citizens of this state, including:

(a) A health maintenance organization issued a certificate of authority under and by virtue of the laws of the State of Arkansas; and

(b) A health insurer, nonprofit health service plan, health insurance service organization, or preferred provider organization or other entity offering health insurance policies, contracts, or benefits in this state.

(B) "Private review agent" does not include automobile, homeowner, or casualty and commercial liability insurers or their employees, agents, or contractors;

(4) "Utilization review" means a system for review which reviews the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients; and

(5) "Utilization review plan" means a description of the utilization review procedures of a private review agent.

History. Acts 1989, No. 537, § 1; 2001, No. 1729, § 1.

20-9-903. Certificate required.

A private review agent who approves or denies payment or who recommends approval or denial of payment for hospital or medical services or whose review results in approval or denial of payment for hospital or medical services on a case-by-case basis may not conduct utilization review in this state unless the State Board of Health has granted the private review agent a certificate.

History. Acts 1989, No. 537, § 3.

20-9-904. When certificate not required.

(a) The State Board of Health may waive the requirements of this subchapter for the activities of a private review agent in connection with a contract with the United States Government for utilization review of patients eligible for hospital and medical services under the Social Security Act.

(b) No certificate is required for those private review agents conducting general in-house utilization review for hospitals, home health agencies, preferred provider organizations, other managed care entities, clinics, private offices, or any other health facilities or entities, so long as the review does not result in the approval or denial of payment for hospital or medical services for a particular case. The general in-house utilization review is exempt from this subchapter.

(c) No certificate is required for utilization review by any Arkansas-licensed pharmacist or pharmacy, or organizations of either, while engaged in the practice of pharmacy, including, but not limited to, dispensing of drugs, participation in drug utilization reviews, and monitoring patient drug therapy.

History. Acts 1989, No. 537, §§ 4, 9. referred to in this section, is codified primarily in Title 42 of the U.S. Code.
U.S. Code. The Social Security Act,

20-9-905. Penalty.

(a) A person who violates any provision of this subchapter or any regulation adopted under this subchapter shall be guilty of a violation and upon conviction shall be subject to a penalty not exceeding one thousand dollars (\$1,000).

(b) Each day that a violation is continued after the first conviction is a separate offense.

History. Acts 1989, No. 537, § 12; Acts 2005, No. 1994, § 108.

20-9-906. Duties of State Board of Health.

(a)(1) In accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq., the State Board of Health shall adopt regulations to implement this subchapter.

(2) Regulations governing utilization review plans under this subchapter shall impose no greater requirements than those required for utilization review activities for state-certified health maintenance organizations under the laws of this state, as amended from time to time.

(3) Any information required by the board with respect to customers, patients, or utilization review procedures of a private review agent shall be held in confidence and not disclosed to the public.

(b) The board shall issue a certificate to an applicant that has met all the requirements of this subchapter and all applicable regulations of the board.

(c) The board may establish reporting requirements to:

(1) Evaluate the effectiveness of private review agents; and

(2) Determine if the utilization review programs are in compliance with this subchapter and applicable regulations.

(d) A certificate issued under this subchapter is not transferrable.

History. Acts 1989, No. 537, §§ 3, 10.

20-9-907. Health insurance plans — Insurers.

(a)(1) Every health insurance plan proposing to issue or deliver a health insurance policy or contract or administer a health benefit program which provides for the coverage of hospital and medical benefits and the utilization review of those benefits shall:

(A) Have a certificate in accordance with this subchapter; or

(B) Contract with a private review agent who has a certificate in accordance with this subchapter.

(2) Notwithstanding any other provisions of this subchapter, for claims in which the medical necessity of the provision of a covered benefit is disputed, a health service plan that does not meet the

requirements of this subsection shall pay any person or hospital entitled to reimbursement under the policy or contract.

(b)(1) Every insurer proposing to issue or deliver a health insurance policy or contract or administer a health benefit program which provides for the coverage of hospital and medical benefits and the utilization review of such benefits shall:

(A) Have a certificate in accordance with this subchapter; or

(B) Contract with a private review agent that has a certificate in accordance with this subchapter.

(2) Notwithstanding any provision of this subchapter, for claims in which the medical necessity of the provision of a covered benefit is disputed, an insurer that does not meet the requirements of this subsection shall pay any person or hospital entitled to reimbursement under the policy or contract.

(c)(1) Any health insurer proposing to issue or deliver in this state a group or blanket health insurance policy or administer a health benefit program which provides for the coverage of hospital and medical benefits and the utilization review of such benefits shall:

(A) Have a certificate in accordance with this subchapter; or

(B) Contract with a private review agent that has a certificate in accordance with this subchapter.

(2) Notwithstanding any provision of this subchapter, for claims in which the medical necessity of the provision of a covered benefit is disputed, a health insurer that does not meet the requirements of this subsection shall pay any person or hospital entitled to reimbursement under the policy or contract.

History. Acts 1989, No. 537, §§ 14-16.

20-9-908. Application for certification — Fee.

(a) An applicant for a certificate shall:

(1) Submit an application to the State Board of Health; and

(2) Pay to the board the application fee established by the board through regulation.

(b) The application shall:

(1) Be on a form and accompanied by any supporting documentation that the board requires; and

(2) Be signed and verified by the applicant.

(c) The application fee required under this section shall be sufficient to pay for the administrative cost of the certification program and any other cost associated with carrying out this subchapter.

(d)(1) All application fees shall be special revenues and deposited to the credit of the Public Health Fund.

(2) Any unexpended balance of such fees at the end of each state fiscal year shall be carried forward to the next fiscal year to be used for the same intent and purposes as set forth in this subchapter.

History. Acts 1989, No. 537, § 5; 1993, No. 1045, § 1.

20-9-909. Information required with application.

In conjunction with the application, the private review agent shall submit information that the State Board of Health requires, including:

- (1) A utilization review plan that includes:
 - (A) A description of review standards and procedures to be used in evaluating proposed or delivered hospital and medical care; and
 - (B) The provisions by which patients, physicians, or hospitals may seek reconsideration or appeal of adverse decisions by the private review agent;
- (2) The type and qualifications of the personnel either employed or under contract to perform the utilization review;
- (3) The procedures and policies to ensure that a representative of the private review agent is reasonably accessible to patients and providers five (5) days a week during normal business hours in this state;
- (4) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;
- (5) A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan; and
- (6) A list of the third party payors for which the private review agent is performing utilization review in this state.

History. Acts 1989, No. 537, § 6.

20-9-910. Expiration of certificate — Renewal.

(a) A certificate expires on the second anniversary of its effective date unless the certificate is renewed for a two-year term as provided in this section.

(b) Before the certificate expires, a certificate may be renewed for an additional two-year term if the applicant:

- (1) Otherwise is entitled to the certificate;
- (2) Pays the State Board of Health the renewal fee set by the board through regulation; and
- (3) Submits to the board:
 - (A) A renewal application on the form that the board requires; and
 - (B) Satisfactory evidence of compliance with any requirement of this subchapter for certificate renewal.

History. Acts 1989, No. 537, § 7.

20-9-911. Revocation or denial of certificate.

(a) The State Board of Health may revoke or deny a certificate if the holder does not comply with performance assurances under this section, violates any provision of this subchapter, or violates any regulation adopted pursuant to this subchapter.

(b) The board shall deny a certificate to any applicant if upon review of the application the board finds that the applicant proposing to conduct a utilization review does not:

(1) Have available the services of a sufficient number of qualified medical professionals supported and supervised by appropriate physicians to carry out its utilization review activities;

(2) Meet any applicable regulations the board adopted under this subchapter relating to the qualifications of private review agents or the performance of utilization review; and

(3) Provide assurances satisfactory to the board that:

(A) The procedure and policies of the private review agent will protect the confidentiality of medical records; and

(B) The review agent will be reasonably accessible to patients and providers for five (5) working days a week during normal business hours in this state.

History. Acts 1989, No. 537, § 8.

20-9-912. Appeals.

(a)(1) Before denying or revoking a certificate under this subchapter, the State Board of Health shall provide the applicant or certificate holder with reasonable time to supply additional information demonstrating compliance with the requirements of this subchapter and the opportunity to request a hearing.

(2) If an applicant or certificate holder requests a hearing, the board shall send a hearing notice and conduct a hearing in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(b) Any person aggrieved by a final decision of the board in a contested case under this subchapter may take a direct judicial appeal as provided for in the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

History. Acts 1989, No. 537, §§ 8, 13.

20-9-913. Confidentiality.

A private review agent may not disclose or publish individual medical records or any other confidential medical information obtained in the performance of utilization review activities without the appropriate procedures for protecting the patient's confidentiality. However, nothing in this subchapter shall prohibit private review agents from providing patient information to a third party whom the private review agent is affiliated with, under contract with, or acting on behalf of.

History. Acts 1989, No. 537, § 11.

20-9-914. Liability unaffected.

Nothing in this subchapter shall be deemed to reduce or expand the liability of any person or entity for any actions or activities with respect to utilization review.

History. Acts 1989, No. 537, § 17.

SUBCHAPTER 10 — ACUTE STROKE CARE ACT OF 2005

SECTION.	SECTION.
20-9-1001. Title.	20-9-1004. Powers and duties.
20-9-1002. Findings.	20-9-1005. State Board of Health — Powers and duties.
20-9-1003. Acute Stroke Care Task Force — Creation.	

20-9-1001. Title.

This subchapter shall be known and may be cited as the “Acute Stroke Care Act of 2005”.

History. Acts 2005, No. 663, § 1.

20-9-1002. Findings.

The General Assembly finds that:

- (1) The citizens of the State of Arkansas are entitled to the maximum protection which is practicable from the effects of strokes;
- (2) Each year about seven hundred thousand (700,000) Americans experience a new or recurrent stroke;
- (3) On average, a stroke strikes someone every forty-five (45) seconds, and someone dies of a stroke every three and one-tenth (3.1) minutes;
- (4) Stroke is the leading cause of serious, long-term disability in the United States, with about four million seven hundred thousand (4,700,000) stroke survivors alive today;
- (5) Stroke is the third leading cause of death in the United States, causing fifty-seven and seven-tenths (57.7) deaths per one hundred thousand (100,000) population; and
- (6) In Arkansas, the death rate from stroke is seventy-five and nine-tenths (75.9) per one hundred thousand (100,000), the highest in the nation.

History. Acts 2005, No. 663, § 1.

20-9-1003. Acute Stroke Care Task Force — Creation.

- (a) There is created the Acute Stroke Care Task Force to consist of twelve (12) members.
- (b) The Director of the Department of Health shall appoint:
 - (1) One (1) member to represent the Department of Health;

(2) One (1) member to represent the American Heart Association and the American Stroke Association;

(3) One (1) member to represent the Arkansas Minority Health Commission;

(4) One (1) member to represent the Arkansas Hospital Association, Inc.;

(5) One (1) member to represent the Arkansas Foundation for Medical Care, Inc.;

(6) One (1) member to represent the Fay W. Boozman College of Public Health of the University of Arkansas for Medical Sciences;

(7) One (1) member to represent the Division of Medical Services within the Department of Human Services;

(8) One (1) member to represent emergency medical services;

(9) One (1) member to represent the Arkansas Medical Society, Inc.;

(10) One (1) member to represent the medical insurance industry;

(11) One (1) member to represent the community at large; and

(12) One (1) member to represent the Arkansas Medical, Dental, and Pharmaceutical Association, Inc.

(c)(1) Except for the initial members, task force members shall serve three-year terms.

(2) The initial members shall be assigned by lot so as to stagger terms to equalize as nearly as possible the number of members to be appointed each year.

(d) If a vacancy occurs, the director shall appoint a person who represents the same constituency as the member being replaced.

(e) The task force shall elect one (1) of its members to act as chair for a term of one (1) year.

(f) A majority of the members shall constitute a quorum for the transaction of business.

(g) The task force shall meet as necessary to further the intent and purpose of this subchapter.

(h) The Department of Health shall provide office space and staff for the task force.

(i) Members of the task force shall serve without pay but may receive expense reimbursement in accordance with § 25-16-902 if funds are available.

History. Acts 2005, No. 663, § 1.

20-9-1004. Powers and duties.

The Acute Stroke Care Task Force shall:

(1) Make recommendations to the State Board of Health consistent with the intent and purpose of this subchapter;

(2) Pursue both public and private funding to further the intent of this subchapter; and

(3) Develop standards and policy recommendations considering, but not limited to, the following:

(A) Methods for raising public awareness of the prevalence and treatment considerations for strokes;

(B) The professional development of emergency medical services professionals to identify victims of potential stroke;

(C) The professional development of emergency room and hospital personnel to identify and treat victims of potential stroke;

(D) Methods for encouraging the use of thrombolytics, clot-busting drugs, or other accepted or emerging treatments, when appropriate;

(E) Methods for ensuring that a comprehensive range of stroke recovery services are available to Arkansans as they recover physical and mental functions affected by a stroke;

(F) Methods for developing stroke treatment centers; and

(G) Methods for developing a stroke registry for Arkansas.

History. Acts 2005, No. 663, § 1.

20-9-1005. State Board of Health — Powers and duties.

The State Board of Health, after consultation with the Acute Stroke Care Task Force and if funds are available, may promulgate rules to further the intent of this subchapter.

History. Acts 2005, No. 663, § 1.

SUBCHAPTER 11 — CERVICAL CANCER CARE ACT OF 2005

SECTION.

20-9-1101. Title.

20-9-1102. Cervical Cancer Task Force —
Creation.

20-9-1103. Cervical Cancer Task Force —
Powers and duties.

SECTION.

20-9-1104. State Board of Health — Pow-
ers and duties.

20-9-1101. Title.

This subchapter shall be known as the “Cervical Cancer Care Act of 2005”.

History. Acts 2005, No. 1414, § 1.

20-9-1102. Cervical Cancer Task Force — Creation.

(a) There is created the Cervical Cancer Task Force to consist of twelve (12) members.

(b) The Director of the Department of Health shall appoint:

(1) One (1) member to represent the Department of Health;

(2) One (1) member to represent the American Cancer Society;

(3) One (1) member to represent the Arkansas Minority Health Commission;

(4) One (1) member to represent the Arkansas Hospital Association, Inc.;

(5) One (1) member to represent the Arkansas Foundation for Medical Care, Inc.;

(6) One (1) member to represent the Fay W. Boozman College of Public Health of the University of Arkansas for Medical Sciences;

(7) One (1) member to represent the Division of Medical Services of the Department of Human Services;

(8) One (1) member to represent primary care physicians;

(9) One (1) member to represent the Arkansas Medical Society, Inc.;

(10) One (1) member to represent the medical insurance industry;

(11) One (1) member to represent the community at large; and

(12) One (1) member to represent the Arkansas Medical, Dental, and Pharmaceutical Association, Inc.

(c)(1) Except for the initial members, task force members shall serve three-year terms.

(2) The initial members shall be assigned by lot so as to stagger terms to equalize as nearly as possible the number of members to be appointed each year.

(d) If a vacancy occurs, the director shall appoint a person who represents the same constituency as the member being replaced.

(e) The task force shall elect one (1) of its members to act as chair for a term of one (1) year.

(f) A majority of the members shall constitute a quorum for the transaction of business.

(g) The task force shall meet as necessary to further the intent and purpose of this subchapter.

(h) The Department of Health shall provide meeting space and administrative support for the task force.

(i) Members of the task force shall serve without pay but may receive expense reimbursement in accordance with § 25-16-902 if funds are available.

History. Acts 2005, No. 1414, § 1;
2009, No. 280, §§ 1, 2.

20-9-1103. Cervical Cancer Task Force — Powers and duties.

(a) The Cervical Cancer Task Force shall:

(1) Make recommendations to the Breast Cancer Control Advisory Board consistent with the intent of this subchapter;

(2) Pursue both public and private funding to further the intent of this subchapter; and

(3) Develop standards and policy recommendations considering, but not limited to, the following:

(A) Methods for raising public awareness of the prevalence, causes, prevention, screening, and treatment considerations for cervical cancer;

(B) Methods for raising the medical community's awareness of the prevalence, causes, prevention, screening, and treatment considerations for cervical cancer; and

- (C) Methods for ensuring that services across the spectrum of causes, prevention, screening, evaluation, and treatment are available to women in Arkansas.
- (b) The Arkansas Central Cancer Registry of the Department of Health shall provide an annual cervical cancer report to the task force.

History. Acts 2005, No. 1414, § 1;
2009, No. 280, § 3.

20-9-1104. State Board of Health — Powers and duties.

After consultation with the Cervical Cancer Task Force and if funds are available, the State Board of Health may promulgate rules to further the intent of this subchapter.

History. Acts 2005, No. 1414, § 1.

SUBCHAPTER 12 — HEALTH FACILITY INFECTION DISCLOSURE ACT OF 2007

SECTION.	SECTION.
20-9-1201. Title.	20-9-1205. Reports regarding healthcare-associated infections.
20-9-1202. Definitions.	20-9-1206. Legislative intent — Privacy and confidentiality.
20-9-1203. Health facility reports.	20-9-1207. Rules.
20-9-1204. Advisory Committee on Healthcare Acquired Infections.	20-9-1208. Funding.

Effective Dates. As to the effective date of this subchapter, see § 20-9-1208.

20-9-1201. Title.

This subchapter shall be known and may be cited as the “Health Facility Infection Disclosure Act of 2007”.

History. Acts 2007, No. 845, § 1.

20-9-1202. Definitions.

As used in this subchapter:

- (1)(A) “Health facility” means any of the following facilities:
- (i) A hospital, outpatient surgery center, public health center, or recuperation center, as those facilities are defined in § 20-9-201; and
 - (ii) Any other facility determined to be a source of healthcare-associated infections and designated as such by the Department of Health.
- (B) “Health facility” does not include:
- (i) A physician’s office unless the office is otherwise licensed as an outpatient surgery center; or
 - (ii) An establishment furnishing primarily domiciliary care;

(2) “Healthcare-associated infection” means a localized or systemic condition in a person that:

(A) Results from adverse reaction to the presence of an infectious agent or a toxin of an infectious agent; and

(B) Was not present or incubating in the person at the time of admission to the health facility; and

(3) “National Healthcare Safety Network” means the secure, internet-based surveillance system managed by the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention created by the Centers for Disease Control and Prevention for accumulating, exchanging, and integrating relevant information on infectious adverse events associated with healthcare delivery.

History. Acts 2007, No. 845, § 1; 2011, No. 634, § 1; 2013, No. 1132, § 3.

“Internet-based”, substituted “Healthcare” for “Health”, and inserted “and Prevention”.

Amendments. The 2013 amendment, in (3), deleted “data collection” following

20-9-1203. Health facility reports.

(a) A health facility shall collect data on healthcare-associated infection rates for the following:

(1) Central line-associated bloodstream infections in an intensive care unit; and

(2) Other categories as provided under § 20-9-1204(e).

(b)(1)(A) A health facility may voluntarily submit quarterly reports to the Department of Health on the health facility’s healthcare-associated infection rates.

(B)(i) If a health facility elects to submit quarterly reports, the reports shall be submitted to the department:

(a) In a format prescribed by the department; and

(b) By April 30, July 31, October 31, and January 31 of each year.

(ii) Each quarterly report shall cover the immediately preceding calendar quarter.

(C) Data in the quarterly reports shall cover a period ending not earlier than one (1) month before the submission of the report.

(2) If the health facility is a division or subsidiary of another entity that owns or operates other health facilities, the quarterly report shall be for the specific division or subsidiary and not for the other entity.

(c)(1) A health facility participating in the Centers for Medicare & Medicaid Services Hospital Inpatient Quality Reporting Program or its successor shall authorize the department to have access to the following information that the health facility submits to the National Healthcare Safety Network:

(A) The name of the health facility; and

(B) Any information submitted to the National Healthcare Safety Network in order to satisfy the requirements of the Centers for Medicare & Medicaid Services Hospital Inpatient Quality Reporting Program.

(2) The information contained in the National Healthcare Safety Network database and obtained by the department under this section may be used by the department for surveillance and prevention purposes only and shall not be used for regulatory purposes.

History. Acts 2007, No. 845, § 1; 2011, No. 634, §§ 2, 3.

20-9-1204. Advisory Committee on Healthcare Acquired Infections.

(a) The Director of the Department of Health shall appoint an Advisory Committee on Healthcare Acquired Infections, including without limitation representatives of:

(1) Public and private hospitals, including representatives of hospitals with fewer than fifty (50) beds and representatives of hospitals with more than fifty (50) beds;

(2) Outpatient surgery centers;

(3) Direct-care nursing staff;

(4) Physicians;

(5) Infection-control professionals with expertise in healthcare-associated infections;

(6) Academic researchers; and

(7) At least one (1) representative of a consumer organization.

(b) The committee shall assist the Department of Health in the development of all aspects of the department's methodology for collecting, analyzing, and disclosing the data collected under this subchapter, including without limitation:

(1) Collection methods;

(2) Formatting; and

(3) Methods and means for the release and dissemination of the data.

(c)(1) In developing the methodology for collecting and analyzing the infection-rate data, the department and the committee shall consider existing methodologies and systems for data collection.

(2) Any data collection and analytical methodologies used shall be:

(A) Capable of being validated; and

(B) Based upon nationally recognized and recommended standards that may include those developed by the Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services, the United States Agency for Healthcare Research and Quality, or the National Quality Forum.

(3) The proposed data collection and analysis methodology shall be disclosed for public comment before any public disclosure of healthcare-associated infection rates in an annual report under § 20-9-1205.

(4)(A) The data collection and analysis methodology shall be presented to all health facilities in this state on or before September 1, 2008.

(B) The methodology may be amended based upon input from the health facilities.

(5)(A) The first voluntary quarterly report under § 20-9-1203(b) shall be presented to the department on or before January 31, 2009.

(B) Health facilities may begin voluntarily reporting data on January 31, 2009, or at any time thereafter.

(d) The department and the committee shall evaluate on a regular basis the quality and accuracy of health facility data reported under this subchapter and the data collection, analysis, and dissemination methodologies used under this subchapter.

(e) After release of the second annual report published under § 20-9-1205 and upon consultation with the committee and with other technical advisors who are recognized experts in the prevention, identification, and control of healthcare-associated infections and the reporting of performance data, the department may add categories of infections to those set forth in § 20-9-1203(a) in compliance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

History. Acts 2007, No. 845, § 1; 2011, No. 634, § 4.

20-9-1205. Reports regarding healthcare-associated infections.

(a)(1)(A) In consultation with the Advisory Committee on Healthcare Acquired Infections, the Department of Health shall submit annually a report summarizing the health facility quarterly reports required under this subchapter to the Chair of the House Committee on Public Health, Welfare, and Labor and the Chair of the Senate Committee on Public Health, Welfare, and Labor.

(B) No health-facility-identifiable data shall be included in the annual report, but aggregate statistical data may be included.

(2) The department shall publish the annual report on the department's website.

(3) The first annual report shall be submitted and published on or before January 1, 2010.

(b) The annual report prepared by the department under this subchapter regarding healthcare-associated infections shall be appropriately risk-adjusted.

(c) The annual report shall include an executive summary written in plain language that shall include without limitation:

(1) A discussion of findings, conclusions, and trends concerning the overall status of healthcare-associated infections in the state, including a comparison to previous years; and

(2) Policy recommendations of the department and the committee.

(d) The annual report shall be made available to any person upon request.

(e) No health facility report or department disclosure shall contain information identifying a patient, employee, or healthcare professional in connection with a specific infection incident.

(f) No annual report or other department disclosure shall contain information that identifies or could be used to identify a specific health facility.

(g)(1) As part of the process of preparing the annual report, effective safeguards to protect against the dissemination of inconsistent, incomplete, invalid, inaccurate, or subjective health facility data shall be developed and implemented.

(2) These safeguards may include the exclusion of certain data or data from health facilities with a low volume of patients or procedures if the use of the data would skew the results reported.

(h) The department shall develop, with the assistance of the committee, a process of regular and confidential feedback for health facilities regarding the data collected so that each health facility's data will be available to that health facility for its quality improvement efforts.

History. Acts 2007, No. 845, § 1.

20-9-1206. Legislative intent — Privacy and confidentiality.

(a) It is the intent of the General Assembly that a patient's right of confidentiality shall not be violated in any manner under this subchapter.

(b) Social Security numbers and any other information that could be used to identify an individual patient shall not be released under this subchapter.

(c) Except for the annual report that shall be a public document available to any person upon request, any data and materials collected or compiled by a health facility or obtained by the Department of Health under this subchapter shall be exempt from discovery and disclosure to the same extent that records of and testimony before committees evaluating quality of medical or hospital care are exempt under § 16-46-105(a)(1) and shall not be admissible in any legal proceeding.

(d) Data collected and reported under this subchapter shall not be deemed to have established a standard of care for any purposes in a private civil litigation.

History. Acts 2007, No. 845, § 1.

20-9-1207. Rules.

The State Board of Health shall promulgate rules to implement this subchapter.

History. Acts 2007, No. 845, § 1.

20-9-1208. Funding.

This subchapter is contingent upon the appropriation and availability of funding necessary for the Department of Health to implement its provisions, and any requirements that actions be accomplished by a specific date shall be extended until the necessary funding is available.

History. Acts 2007, No. 845, § 1.

SUBCHAPTER 13 — ARKANSAS PEER REVIEW FAIRNESS ACT

SECTION.

- 20-9-1301. Title.
 20-9-1302. Findings and intent.
 20-9-1303. Definitions.
 20-9-1304. Standards for professional review actions and professional review activities.
 20-9-1305. [Repealed.]
 20-9-1306. Suspensions.
 20-9-1307. [Repealed.]

SECTION.

- 20-9-1308. Relationship to other laws and regulations.
 20-9-1309. Standards for investigations.
 20-9-1310. Standards for hearings and related matters.
 20-9-1311. Nonwaivable.
 20-9-1312. Applicability.
 20-9-1313. Remedy.

A.C.R.C. Notes. Acts 2017, No. 975, § 8, provided: “SEVERABILITY CLAUSE. If any provision of this act or the application of this act to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application, and to this end, the provisions of this act are declared severable.”

Effective Dates. Acts 2017, No. 975, § 9: Apr. 7, 2017, § 7. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that without legislative action, participants in medical staff peer review proceedings will continue to be confused and uncertain as to what remedies are available to address an unfair peer review proceeding and the scope of judicial review; that the standards established in SECTION 7 of this act will help remedy

the confusion and uncertainty, prevent harm to physicians and physician-patient relationships, and promote fair independent medical judgment; and that SECTION 7 of this act is immediately necessary to provide a fair process to the physician under review while still providing immunity to individuals serving on professional review bodies. Therefore, an emergency is declared to exist, and SECTION 7 of this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

20-9-1301. Title.

This subchapter shall be known and may be cited as the “Arkansas Peer Review Fairness Act”.

History. Acts 2013, No. 766, § 1.

CASE NOTES

Constitutionality.

Circuit court erred in denying the defendants’ motion for summary judgment in the hospitals’ action to declare the Arkansas Peer Review Fairness Act, § 20-9-1301 et seq., unconstitutional because a justiciable controversy had not been pre-

sented for review where the hospitals did not state that they were violating the Act, did not allege a threat of imminent enforcement under the Act, and did not present a sufficient factual record to show an actual, present controversy, which was a necessary element of a declaratory-judg-

ment suit. Baptist Health Sys. v. Rutledge, 2016 Ark. 121, 488 S.W.3d 507 (2016).

20-9-1302. Findings and intent.

- (a) The General Assembly finds that:
 - (1) The peer review process is well established as an acceptable means of monitoring quality and improving care within an institution;
 - (2)(A) The peer review process faces unique challenges in the hospital setting compared to other healthcare settings due to the interdependent relationship between the hospital and medical staff, which can impact professional review activities.
 - (B) Peer review that is not conducted fairly results in harm to both patients and physicians by limiting access to care and patient choice; and
 - (3) It is necessary to balance carefully the rights of patients who benefit by properly conducted peer review with the rights of those who may be harmed by improper peer review.
- (b) The General Assembly intends that peer review be conducted fairly for the benefit of the citizens of the State of Arkansas.

<p>History. Acts 2013, No. 766, § 1; 2017, No. 975, § 1.</p> <p>Amendments. The 2017 amendment substituted “an acceptable” for “the most important and effective” in (a)(1); rewrote</p>	<p>(a)(2)(A); deleted “However” preceding “Peer review” at the beginning of (a)(2)(B); and inserted “properly conducted” in (a)(3).</p>
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20-9-1303. Definitions.

- As used in this subchapter:
- (1) “Adversely affect”, when used in reference to clinical privileges or medical staff membership, means deny, reduce, restrict, suspend, revoke, or fail to renew;
 - (2) “Conflict of interest” means a personal or financial interest that would lead an objective person to conclude that it would be difficult for the person in those circumstances to make a fair and impartial decision in a professional review activity with regard to a particular physician;
 - (3) “Hospital” means a healthcare facility licensed as a hospital by the Division of Health Facilities Services under § 20-9-213;
 - (4)(A) “Investigation” means a process conducted by a professional review body to:
 - (i) Obtain and make a detailed examination of the facts related to an identified concern about a specific physician; and
 - (ii) Determine whether a professional review action should be requested or recommended.
 - (B) “Investigation” does not include the following:
 - (i) A preliminary review to obtain basic information related to a concern or complaint about a physician in order to determine whether an investigation should commence;

(ii) Routine quality assurance, case review, utilization review, and performance improvement activities that take place within a hospital; or

(iii) Collegial interventions, ongoing physician practice evaluations and focused physician practice evaluations, and other peer-to-peer performance improvement interventions that are not intended to, and do not, impact a physician's clinical privileges or hospital medical staff membership;

(5) "Medical staff" means the physicians who are approved and given privileges to provide health care to patients in the hospital;

(6) "Professional review action" means an action or recommendation of a professional review body that is taken or made in the conduct of professional review activity and that:

(A) Is based on an individual physician's competence or professional conduct that adversely affects or could adversely affect the health or welfare of a patient or patients; and

(B) Adversely affects or may adversely affect the medical staff membership or clinical privileges of the physician;

(7)(A) "Professional review activity" means an activity with respect to an individual physician:

(i) To determine whether the physician may have clinical privileges at a hospital or membership on the hospital's medical staff;

(ii) To determine the scope or conditions of clinical privileges or medical staff membership; or

(iii) To change or modify such clinical privileges or medical staff membership.

(B) "Professional review activity" includes an investigation, as defined in this section; and

(8) "Professional review body" means a hospital, its governing body, or its medical staff when any of these bodies are conducting a professional review activity.

History. Acts 2013, No. 766, § 1; 2017, No. 975, § 1.

Amendments. The 2017 amendment added the definition for "Conflict of interest"; deleted the definition for "Governing body"; redesignated former (4) as (4)(A) and rewrote it; added (4)(B); deleted "and

other licensed practitioners" following "physicians" in (5); substituted "medical staff membership" for "hospital membership" in (6)(B); substituted "on" for "in" in (7)(A)(i); deleted "such" preceding "clinical" in (7)(A)(ii); deleted (8)(B); and made stylistic changes.

20-9-1304. Standards for professional review actions and professional review activities.

(a) Professional review activity shall be conducted and professional review actions shall be taken in compliance with the requirements of the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 et seq., and the additional requirements of this subchapter.

(b)(1) If at any meeting or hearing held in the course of a professional review activity, an attorney is participating on behalf of a professional review body and the physician under review is present, then the

physician under review shall be permitted to have the attorney of the physician present.

(2) Subdivision (b)(1) of this section does not:

(A) Entitle the attorney of the physician to appear at any meeting or hearing where an attorney participating on behalf of the peer review body is not present, except as provided in § 20-9-1310;

(B) Prohibit confidential attorney-client communications by any party; or

(C) Prohibit a professional review body from meeting in private with its attorney.

(c) The General Assembly encourages:

(1) Professional review bodies to use separate legal counsel from the legal counsel used by the hospital; and

(2) Medical staff to obtain independent legal counsel to review medical staff bylaws to ensure that the bylaws contain provisions that comply with this subchapter.

(d)(1) A physician engaged in professional review activities shall exercise unbiased, independent, and professional judgment when evaluating another physician.

(2) A hospital shall not take action against or otherwise retaliate against a physician for exercising unbiased, independent, and professional judgment when evaluating another physician during the course of a professional review activity.

History. Acts 2013, No. 766, § 1; 2017, No. 975, § 1.

Amendments. The 2017 amendment rewrote the section.

20-9-1305. [Repealed.]

Publisher's Notes. This section, concerning medical staff bylaws, was repealed by Acts 2017, No. 975, § 2. The

section was derived from Acts 2013, No. 766, § 1. For current law, see § 20-9-1304(c).

20-9-1306. Suspensions.

(a) If failure to take a professional review action may result in an imminent danger to the health of any individual, the hospital may immediately suspend or restrict the medical staff membership or clinical privileges of a physician.

(b) If an action is taken under subsection (a) of this section, then the hospital shall follow all the other provisions of this subchapter as soon as practicable following the suspension or restriction.

(c) In the case of a suspension or restriction of clinical privileges, for a period of not longer than fourteen (14) days, during which an investigation is being conducted to determine the need for a professional review action:

(1) No hearing is required to be held regarding the suspension;

(2) The parties shall comply with § 20-9-1309 and all other applicable provisions of this subchapter; and

(3) The physician shall be given the opportunity to discuss the case with the individual or individuals conducting the investigation during the fourteen (14) days before any recommendation or decision is made about continuing the suspension or restriction.

History. Acts 2013, No. 766, § 1; 2017, No. 975, § 3.

Amendments. The 2017 amendment substituted “parties shall comply with §

20-9-1309 and all other applicable” for “professional review body shall follow the notice” in (c)(2).

20-9-1307. [Repealed.]

Publisher’s Notes. This section, concerning actions for equitable relief permitted, was repealed by Acts 2017, No. 975, §

4. The section was derived from Acts 2013, No. 766, § 1. For current law, see § 20-9-1313.

20-9-1308. Relationship to other laws and regulations.

(a)(1) Except as provided in subsection (b) of this section, professional review activities are within the categories of records and proceedings that are exempt from discovery and disclosure under state law, including without limitation § 16-46-105(a)(1) and § 20-9-503.

(2) This subchapter does not affect the admissibility in evidence in any action or proceeding of the medical records of any patient.

(b) This subchapter does not:

(1) Abrogate the immunity provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 et seq., or the confidentiality or immunity provisions of § 16-46-105, § 17-1-102, or § 20-9-501 et seq.; or

(2) Prevent discovery and admissibility of evidence from the professional review activities if the legal action is brought by a physician who has been subjected to the professional review activity or action.

History. Acts 2013, No. 766, § 1; 2017, No. 975, § 5.

Amendments. The 2017 amendment

rewrote (a)(1); substituted “This subchapter does not” for “Nothing in this subchapter shall” in (a)(2); and rewrote (b).

20-9-1309. Standards for investigations.

(a) A physician shall be informed in writing within five (5) business days of the date that the physician becomes a subject of an investigation.

(b) Before a professional review body makes a recommendation as a result of an investigation, the physician under review shall be given an opportunity to have a meeting with the professional review body to discuss the matter without the presence of attorneys.

(c)(1)(A) If the professional review body decides to use an external review during the investigation, physicians serving on the professional review body that is conducting the investigation are responsible for selecting any external reviewers and the method of selecting cases for review.

(B) However, the physicians serving on the professional review body may seek input regarding the selection described under subdivision (c)(1)(A) of this section from the physician under review or other individuals.

(2) The physician under review shall be included on any substantive communications by any party with the external reviewers selected under subdivision (c)(1)(A) of this section.

(d) At the conclusion of the investigation, the physician under review shall be informed of the determination of the professional review body.

History. Acts 2017, No. 975, § 6.

20-9-1310. Standards for hearings and related matters.

(a)(1) A physician who is the subject of a proposed professional review action shall be given notice of the proposed professional review action, the basis for the proposed professional review action, and the right to a hearing.

(2) Subdivision (a)(1) of this section does not entitle a physician to a hearing if the proposed professional review action will not adversely affect the physician's clinical privileges or medical staff membership.

(b)(1) A hearing shall be held before a hearing officer, arbitrator, hearing panel, or combination of hearing officer, arbitrator, or hearing panel.

(2) A hearing officer or arbitrator shall:

(A) Be independent of all parties involved;

(B) Have no conflict of interest; and

(C) Not:

(i) Have served as an attorney for the hospital or the physician under review at any time within two (2) years before the hearing date; or

(ii) Be affiliated with a law firm that has represented the hospital or the physician under review at any time within two (2) years before the hearing date.

(3)(A) The medical staff bylaws shall govern the appointment of members of a hearing panel subject to the requirements of this subsection.

(B) The members of a hearing panel may be members of the medical staff of the hospital.

(C) The members of the hearing panel shall:

(i) Disclose any potential conflicts of interest before the hearing; and

(ii) Agree to exercise unbiased, independent, and professional judgment when evaluating the competence or professional conduct of the physician under review.

(4)(A) A physician under review shall have a reasonable opportunity to raise the issue of a potential conflict of interest or other concern related to a hearing officer, arbitrator, or member of a hearing panel.

(B) The medical staff bylaws shall establish a process for considering and resolving any potential conflicts of interest.

(c)(1) Before the hearing, the professional review body and the physician under review shall provide the opposing party with a list of any witnesses expected to testify and copies of any documents expected to be introduced at the hearing.

(2) In advance of the hearing, the hospital administration, professional review body, and the physician under review shall disclose all relevant information to each other.

(d) At the hearing, the physician under review shall have the right to:

(1) Be present and present evidence on his or her own behalf;

(2) Be represented by an attorney or another individual of the physician's choice at the hearing;

(3) Call, examine, and cross-examine witnesses; and

(4) Submit a written statement.

(e) Upon completion of the hearing, the physician under review has a right to receive:

(1) The written recommendation of the hearing officer, arbitrator, or hearing panel, including a statement of the basis of the recommendation; and

(2) A copy of the record of the hearing upon request and payment of any reasonable charges for the preparation of the record.

(f) After the hospital takes final action on the recommendation from the hearing, the physician under review is entitled to receive a written decision, including a statement of the basis for the decision.

(g) Any dispute over the relevancy or method of discovery or any other dispute that arises during the hearing process shall be resolved by the hearing officer, arbitrator, or hearing panel.

History. Acts 2017, No. 975, § 6.

20-9-1311. Nonwaivable.

(a) Unless part of a mutually agreed upon mediation or settlement, a provision in an agreement, policy, procedure, or contract, including bylaws, that purports to waive any provision of this subchapter is void.

(b) However, the time periods for compliance with procedural requirements may be waived by mutual consent of the parties on a case-by-case basis.

History. Acts 2017, No. 975, § 6.

20-9-1312. Applicability.

On and after August 1, 2017, this subchapter shall apply to any investigation or professional review activity at any stage.

History. Acts 2017, No. 975, § 6.

20-9-1313. Remedy.

(a) Within sixty (60) days of a final decision that adversely affects a physician, a physician may file a petition to remedy a violation of this subchapter by filing the petition in:

(1) The circuit court of the county in which the professional review activity occurred; or

(2) The circuit court of an adjoining county.

(b)(1) After receiving a petition, the court shall review the record of the professional review activities and professional review action.

(2) The record shall consist of:

(A) The transcripts and minutes of any meetings or hearings;

(B) Correspondence;

(C) Internal and external reviews; and

(D) All other relevant information pertaining to the matter before the professional review body.

(3) The hospital shall transmit the record, but the court may require or permit subsequent corrections or additions to the record.

(4) The review conducted by the court shall be confined to the record, except upon a showing of good cause to go beyond the record.

(5) The court may hear, upon request, oral arguments and receive written briefs.

(6) Absent a showing of bad faith, a member of the medical staff who participated in the professional review activity shall not be compelled to testify in court under this subsection.

(c) Except as provided in subsection (e) of this section, the court may order any relief within the purview of the circuit court to remedy the violation of this subchapter.

(d)(1) If a physician prevails under this section, the physician shall be entitled to reasonable attorney's fees, costs, and expenses as determined by the court.

(2) A defendant who prevails shall be entitled to reasonable attorney's fees, costs, and expenses as determined by the court to the extent permitted under the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11113, as existing on January 1, 2017.

(e) Except as expressly permitted by state law or federal law, a professional review body or its members, agents, or employees are not liable for civil damages as a result of making a decision or recommendation in good faith in connection with a professional review activity or professional review action or furnishing any records, information, or assistance in good faith to a professional review body in connection with a professional review activity.

(f)(1) The remedies provided for in this section do not supplant any other remedy available under law to a physician.

(2) If a physician has more than one (1) cause of action, all causes of action may be joined in the same pleading.

**SUBCHAPTER 14 — CARTER'S LAW: THE SHAKEN BABY SYNDROME
EDUCATION PROGRAM**

SECTION.

20-9-1401. Definitions.

20-9-1402. Shaken baby syndrome education program established.

20-9-1403. Distribution of shaken baby syndrome educational materials.

SECTION.

20-9-1404. Data on shaken baby syndrome.

20-9-1405. Rules.

20-9-1401. Definitions.

As used in this subchapter:

(1) "Child care facility" means a facility licensed under the Child Care Facility Licensing Act, § 20-78-201 et seq.;

(2) "Freestanding birthing center" means a facility, institution, or place, which is not an ambulatory surgical center or a hospital or in a hospital, organized to provide family-centered maternity care for women and childbearing families in which births are planned to occur in a homelike atmosphere away from the mothers' residences following a low-risk pregnancy;

(3) "Hospital" means an institution that has been licensed, certified, or approved by the Division of Health Facilities Services as a hospital;

(4)(A) "Maternity unit" means a unit or place in a hospital in which women are regularly received and provided care during all or part of the maternity cycle.

(B) "Maternity unit" does not include an emergency department or similar place dedicated to providing emergency health care;

(5) "Parent" means:

(A) Either parent;

(B) If the parents are separated or divorced or their marriage has been dissolved or annulled, the parent who is the residential parent and legal custodian of the child; and

(C) A prospective adoptive parent with whom a child is placed; and

(6) "Shaken baby syndrome" means signs and symptoms resulting from the violent shaking or the shaking and impacting of the head of an infant or child, including without limitation:

(A) Retinal hemorrhage;

(B) Subdural hematoma; and

(C) Cerebral edema.

History. Acts 2013, No. 1208, § 2.

20-9-1402. Shaken baby syndrome education program established.

(a) The Director of the Department of Health shall establish the shaken baby syndrome education program by:

(1) Not later than one (1) year after August 16, 2013, developing educational materials that present readily comprehensible information for new parents on shaken baby syndrome; and

(2) Making available on the Department of Health website in an easily accessible format the educational materials developed under subdivision (a)(1) of this section.

(b)(1) An individual or entity may create educational materials concerning shaken baby syndrome.

(2) An individual or entity that develops educational materials under subdivision (b)(1) of this section shall submit the materials for approval by the department before distributing the educational materials.

(3) If the department approves educational materials submitted under subdivision (b)(2) of this section, the individual or entity may distribute the educational materials at the individual's or entity's expense.

(c)(1) Annually beginning on or before January 1, 2014, the director shall assess the effectiveness of the shaken baby syndrome education program.

(2) The department shall submit a biennial report of the assessment under subdivision (c)(1) of this section to the Chair of the House Committee on Public Health, Welfare, and Labor and the Chair of the Senate Committee on Public Health, Welfare, and Labor.

History. Acts 2013, No. 1208, § 2.

20-9-1403. Distribution of shaken baby syndrome educational materials.

(a) A copy of the shaken baby syndrome educational materials developed under § 20-9-1402 or comparable material shall be distributed:

(1) By a child birth educator, a pediatric physician's office, or an obstetrician's office to an expectant parent who uses the services of the child birth educator or staff;

(2) By a hospital or freestanding birthing center in which a child is born to the child's parent who is present at the hospital or freestanding birthing center before the child is discharged from the facility;

(3) By a child care facility to the parent with whom the child resides; and

(4) By a child care facility to each employee of the child care facility.

(b) An entity or a person required to distribute educational materials under subsection (a) of this section is not subject to civil or criminal liability for an injury, a death, or a loss to a person or property resulting from the dissemination of, or failure to disseminate, the educational materials.

History. Acts 2013, No. 1208, § 2.

20-9-1404. Data on shaken baby syndrome.

(a) At the conclusion of a child maltreatment investigation under the Child Maltreatment Act, § 12-18-101 et seq., if a child has been shaken or has an abusive or nonaccidental head trauma, the investigative agency shall identify the type of physical abuse in the child welfare information system.

(b) The Department of Human Services shall include data on the number of children who suffer abusive head trauma, nonaccidental head trauma, and shaken baby syndrome in the annual Arkansas Child Welfare Report Card required under § 9-32-204.

History. Acts 2013, No. 1208, § 2.

20-9-1405. Rules.

The State Board of Health shall adopt rules to implement this subchapter.

History. Acts 2013, No. 1208, § 2.

CHAPTER 10**LONG-TERM CARE FACILITIES AND SERVICES****SUBCHAPTER.**

1. GENERAL PROVISIONS.
2. OFFICE OF LONG-TERM CARE.
3. LONG-TERM CARE FACILITY ADVISORY BOARD. [REPEALED.]
4. LICENSING OF LONG-TERM CARE FACILITY ADMINISTRATORS.
5. LONG-TERM CARE NETWORK.
6. LONG-TERM CARE OMBUDSMAN ACT.
7. LONG-TERM CARE AIDE TRAINING ACT.
8. HOME HEALTHCARE SERVICES.
9. ARKANSAS LONG-TERM CARE FACILITY RECEIVERSHIP LAW.
10. OMNIBUS LONG-TERM CARE REFORM ACT OF 1988.
11. NURSING HOME LICENSING. [REPEALED.]
12. PROTECTION OF LONG-TERM CARE FACILITY RESIDENTS.
13. NURSING HOME RESIDENT AND EMPLOYEE IMMUNIZATION ACT OF 1999.
14. STAFFING REQUIREMENTS FOR NURSING FACILITIES.
15. ALZHEIMER'S SPECIAL CARE STANDARDS ACT.
16. QUALITY ASSURANCE LEVY.
17. ARKANSAS ASSISTED LIVING ACT.
18. LONG-TERM CARE FACILITIES EMERGENCY GENERATOR ACT OF 2001.
19. DISPUTE RESOLUTION FOR LONG-TERM CARE FACILITIES.
20. UNLICENSED LONG-TERM CARE FACILITIES ACT.
21. ARKANSAS OPTIONS COUNSELING FOR LONG-TERM CARE PROGRAM.
22. LONG-TERM CARE QUALITY ASSURANCE.
23. PERSONAL CARE SERVICE PROVIDERS.

A.C.R.C. Notes. Acts 1995, No. 164, § 3, provided: "Any reference to the Division of Economic and Medical Services, or to the Director or Deputy Director thereof,

contained in Title 20, Chapter 10, of the Arkansas Code of 1987 Annotated, shall be deemed to refer to the Division of Medical Services, or the Director thereof.”

RESEARCH REFERENCES

ALR. False imprisonment in connection with confinement in nursing home or hospital. 4 A.L.R.4th 449.
Civil liability for physical measures undertaken in connection with treatment of persons with mental disabilities. 8 A.L.R.4th 464.
Judicial power to order discontinuance of life-sustaining treatment. 48 A.L.R.4th

67.
Criminal liability under statutes penalizing abuse or neglect of institutionalized residents and patients. 60 A.L.R.4th 1153.
Am. Jur. 40A Am. Jur. 2d, Hospitals, §§ 2, 5, 6, 34.

SUBCHAPTER 1 — GENERAL PROVISIONS

SECTION.
20-10-101. Definitions.
20-10-102. [Repealed.]
20-10-103. Post-acute head injury treatment facilities.
20-10-104. Photographing prohibited — Exceptions.
20-10-105. Residential care facility — Ineligibility for reimbursement — Exclusions.
20-10-106. Nursing home alternatives — Income eligibility for participation in state funding.
20-10-107. Long-term care facility — Notice of certain incidents — Definition.

SECTION.
20-10-108. Quality of dietary management in long-term care facilities.
20-10-109. Findings — Intent.
20-10-110. Protection of residents’ personal funds — Definitions.
20-10-111. Disclosure statement for residential care and assisted living facilities.
20-10-112. Results of a survey, inspection, or investigation prohibited in advertisements.

Effective Dates. Acts 1969, No. 58, § 17: Jan. 1, 1970.
Acts 1979, No. 28, § 15: Feb. 1, 1979. Emergency clause provided: “It is hereby found and determined by the General Assembly that there is a need for an Office of Long Term Care and that the immediate passage of this Act is necessary in order that the reorganization contemplated by this Act may be accomplished on or before July 1, 1979. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval.”
Acts 1987, No. 602, § 5: Apr. 4, 1987. Emergency clause provided: “It is hereby found and determined by the General As-

sembly that in order to meet the State’s responsibility in assuring that head injured individuals are afforded a high quality of services and to further enhance the effective and coordinated regulation of long term care facilities through the functions of the Office of Long Term Care the immediate passage of this Act is necessary. Therefore, an emergency is hereby declared to exist and this Act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval.”
Acts 1988 (4th Ex. Sess.), No. 17, § 6: July 15, 1988. Emergency clause provided: “It is hereby found and determined by the General Assembly that the state lacks procedures to adequately protect the

infirm and frail elderly who reside in long-term care facilities within this state; That this act should go into effect immediately upon passage to shorten the amount of time required for necessary rules and regulations to be promulgated for implementation of this act and to provide at the earliest possible date some assurance to the residents of long-term care facilities that a high quality of life and the protection of their welfare and health is necessary and important to the entire citizenry of the State of Arkansas. Therefore, an emergency is hereby declared to exist and this act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1991, No. 1085, § 35: July 1, 1991. Emergency clause provided: "It is hereby found and determined by the Seventy-Eighth General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness of this Act on July 1, 1991 is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1,

1991 could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 1991."

Acts 2005, No. 2191, § 11: Apr. 13, 2005. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that various long-term care facilities are operating in this state without having obtained a license; that there is no state oversight or protection for the vulnerable residents in these facilities; and that there is no way of ensuring that the facilities properly treat and protect these residents under state long-term care laws. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

20-10-101. Definitions.

As used in this chapter:

(1) "Administrative remedy" means temporary management, denial of payment for all new admissions, transfer of residents, termination or suspension of license, termination of provider agreement, directed plan of correction, directed in-service training, and remedies established by Arkansas law, including remedies provided in § 20-10-1408;

(2) "Administrator-in-training program" means a program for gaining supervised practical experience in long-term care administration;

(3) "Assisted living facility" means the same as in § 20-10-1703;

(4) "Clock hour" means a period of contact experience comprising the full sixty (60) minutes;

(5) "Department" means the Department of Human Services;

(6) "Director" means the Director of the Department of Human Services;

(7) "Division" means the appropriate division as determined by the Director of the Department of Human Services;

(8) "Head injury" means a noncongenital injury to the brain or a neurological impairment caused by illness, accident, or nondegenerative etiology;

(9) “Head injury retraining and rehabilitation” means an individualized program of instruction designed to assist an individual suffering disability as a result of head injury to reduce the adverse effects of the disability and improve functioning in activities of daily living and work-related activities, but which does not include inpatient diagnostic care, and which may be offered in a residential or day program;

(10)(A) “Long-term care facility” means a nursing home, residential care facility, assisted living facility, post-acute head injury retraining and residential care facility, or any other facility which provides long-term medical or personal care.

(B) “Long-term care facility” does not include an adult day care program that:

(i) Provides care and supervision to meet the needs of twelve (12) or fewer functionally impaired adults at any time in a place other than the adult’s home;

(ii) Provides services to clients for periods of four (4) hours or less per day for only one (1) day per week;

(iii) Designates an individual to act as the program director to have responsibility for the operation of the program;

(iv) Posts a notice in eighteen-point type that:

(a) Is located at or near the main entrance to the structure in which the program operates;

(b) Lists the name and contact information of the program director;

(c) Lists the name and the contact telephone number for the Adult Protective Services Unit of the Department of Human Services; and

(d) Lists the name and the contact telephone number for the Office of Long-Term Care;

(v) Operates in a building or structure that is at all times in compliance with safety code requirements as determined by the local fire authority; and

(vi) Operates in accordance with the Alzheimer’s Association Dementia Care Practice Recommendations or similarly nationally recognized standards for the treatment and care of individuals with Alzheimer’s disease or related dementia, as in existence on January 1, 2009;

(11) “Long-term care facility administrator” means a person who administers, manages, supervises, or is in general administrative charge of a long-term care facility whether or not the individual has an ownership interest in the long-term care facility and whether or not his or her functions and duties are shared with one (1) or more individuals;

(12) “Post-acute head injury residential care” means a residential program offering assistance in activities of daily living for individuals who are disabled because of head injury and are therefore unable to live independently;

(13) “Post-acute head injury residential care facility” means a residential care facility which is not a nursing home and which provides head injury retraining and rehabilitation for individuals who are

disabled because of head injury and are not in present need of inpatient diagnostic care in a hospital or related institution;

(14) "Reciprocity licensing" means a method by which an individual licensed in good standing in one (1) state may apply for licensure status in another state, provided that the state from which the individual wishes to transfer has standards comparable to the state to which the individual wishes to transfer;

(15) "Residential care facility" means a building or structure which is used or maintained to provide for pay on a twenty-four-hour basis a place of residence and board for three (3) or more individuals whose functional capabilities may have been impaired but who do not require hospital or nursing home care on a daily basis but who could require other assistance in activities of daily living; and

(16) "Sponsor" means legal guardian.

History. Acts 1969, No. 58, § 1; 1975, §§ 1, 2; 1988 (4th Ex. Sess.), No. 17, § 2; No. 119, § 1; 1979, No. 28, § 1; 1985, No. 1993, No. 1090, § 1; 1993, No. 1238, § 4; 884, § 3; 1985, No. 968, § 3; A.S.A. 1947, 2005, No. 898, § 1; 2005, No. 2191, § 2; §§ 82-2201, 82-2216; Acts 1987, No. 602, 2007, No. 827, § 150; 2009, No. 357, § 1.

CASE NOTES

Cited: Ark. Residential Assisted Living Ass'n v. Ark. Health Servs. Permit Comm'n, 364 Ark. 372, 220 S.W.3d 665 (2005); Hale v. Coffman, 2016 Ark. 36, 480 S.W.3d 861 (2016).

20-10-102. [Repealed.]

Publisher's Notes. This section, concerning disposition of funds, was repealed by Acts 1993, No. 1238, § 9. The section was derived from Acts 1969, No. 58, § 14; 1983, No. 738, § 1; A.S.A. 1947, § 82-2214.

20-10-103. Post-acute head injury treatment facilities.

(a) No certificate of need or permit shall be required under any law in connection with facilities offering head injury retraining and rehabilitation.

(b) Post-acute head injury residential facilities shall not be eligible to receive any state Medicare or Medicaid moneys.

History. Acts 1987, No. 602, § 3.

20-10-104. Photographing prohibited — Exceptions.

(a) Except as provided in subsection (d) or subsection (e) of this section, a resident of a long-term care facility in this state shall not be photographed without obtaining prior written consent from the resident or, in cases of incapacity, from the guardian or legal representative of the resident.

(b)(1) When an employee or agent of a long-term care facility photographs a resident under conditions in which consent is required,

the evidence of the consent shall be maintained in the file of the resident at the long-term care facility.

(2) The consent described in subdivision (b)(1) of this section shall be continuously effective unless the consent is rescinded in writing by the resident or the guardian or legal representative of the resident.

(c) Failure to obtain consent before photographing a resident in a long-term care facility shall be a Class B misdemeanor.

(d) This section does not prevent:

(1) A person licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., from photographing a patient for purposes of medical treatment;

(2) A person licensed by the Arkansas State Board of Nursing from photographing a patient for purposes of medical treatment;

(3) Facility staff or agents from photographing a resident of a long-term care facility on social occasions; or

(4) The taking of a photograph by security cameras or other devices for the safety or security of residents.

(e)(1) The photographing of residents is permitted without written consent from the resident or the guardian or legal representative of the resident when the photographing is in connection with a survey or investigation made by the Department of Human Services, the Office of the Attorney General, or the United States Department of Health and Human Services, or any agent of the listed entities while in the course of:

(A) Licensure inspections;

(B) Medicaid certification;

(C) A complaint investigation; or

(D) An investigation of allegations of abuse or neglect of residents or misappropriation of residents' property.

(2) Under the circumstances listed in subdivision (e)(1) of this section, the photographs shall be used only for evidentiary purposes concerning the alleged violations and shall not be released to the media or to the public but shall be made available to the facility if utilized to impose a remedy or to set forth a statement of deficiency.

History. Acts 1989, No. 33, § 2; 1999, No. 709, § 1; 2017, No. 568, § 1.

Amendments. The 2017 amendment rewrote the section.

20-10-105. Residential care facility — Ineligibility for reimbursement — Exclusions.

(a) Any facility that meets the definition of a residential care facility as defined by the Office of Long-Term Care that has not been licensed or certified by the appropriate state agency or has not received a permit of approval from the Health Services Permit Agency shall not be eligible for any reimbursement from state revenues for any services that it offers.

(b) This section does not apply to residential care facilities that have been exempted by law from the permit-of-approval process.

History. Acts 1991, No. 1085, § 25; 1991, No. 922, § 16; 2001, No. 1800, § 15; 2005, No. 2191, § 3.

20-10-106. Nursing home alternatives — Income eligibility for participation in state funding.

(a) The maximum income eligibility for participation in state funding for nursing home alternatives shall be established at two hundred percent (200%) of the Supplemental Security Income level as provided by law.

(b) This section shall in no way affect the Medicaid program or the Medicaid eligibility or benefits of any person.

History. Acts 1991, No. 1157, §§ 1, 2.

20-10-107. Long-term care facility — Notice of certain incidents — Definition.

(a) As used in this section, “long-term care facility” means “long-term care facility” as defined by § 20-10-213.

(b)(1) Within twenty-four (24) hours after the incident requiring notification occurs, a long-term care facility shall notify, if known, the resident’s guardian or other responsible party when:

(A) The resident suffers an injury;

(B) The resident is taken outside the facility for medical care;

(C) The resident is moved to a different room; or

(D) There is any significant change in the physical or mental condition of the resident.

(2) A long-term care facility that does not comply with this subsection commits a Class C violation under § 20-10-205 and is subject to a civil penalty under § 20-10-206.

(c)(1) It is the responsibility of the long-term care facility to obtain an address and telephone number at which the resident’s guardian or other responsible party is available for notification.

(2) It is the responsibility of the resident’s guardian or other responsible party to notify the long-term care facility of any change in address or telephone number.

History. Acts 1993, No. 1123, §§ 1-4; 2005, No. 1994, § 109; 2011, No. 190, § 1; 2013, No. 1132, § 4.

Amendments. The 2013 amendment inserted “commits a Class C violation under § 20-10-205 and” in (b)(2).

20-10-108. Quality of dietary management in long-term care facilities.

(a) Persons responsible for the direction of food services in long-term care facilities having more than fifty (50) beds, at a minimum, shall be:

(1) Certified as a certified dietary manager or food service supervisor; or

(2) Enrolled in a food service supervisor's course approved by the Office of Long-Term Care.

(b)(1) Certified dietary managers or food service supervisors shall be required to complete fifteen (15) hours of continuing education per year.

(2) The continuing education courses shall be offered by the Association of Nutrition and Foodservice Professionals or a comparable body and shall be approved by the office in order for the courses to be counted toward completion of the fifteen (15) hours.

(c) Long-term care facilities having fifty (50) or fewer beds shall allot adequate hours per week for the certified dietary manager or food service supervisor to perform supervisory duties.

History. Acts 1999, No. 1362, §§ 1-3; 2007, No. 827, § 151.

20-10-109. Findings — Intent.

(a) The General Assembly finds that:

(1) Residents in Arkansas' long-term care facilities are particularly vulnerable to the theft or illegal diversion of personal funds designated as residents' share of cost under the Arkansas Medicaid program;

(2) The theft or illegal diversion of residents' share of cost under the program has an adverse impact on the resources available to ensure high-quality care for all facility residents; and

(3) This section and § 20-10-110 are necessary to:

(A) Protect long-term care residents' rights;

(B) Provide appropriate resources for residents' care; and

(C) Ensure that residents' funds designated to pay for long-term care are used for that purpose.

(b) The General Assembly intends that this section and § 20-10-110 affect individuals who intentionally steal or divert residents' share of cost and not change the obligations or responsibilities of residents of long-term care facilities or deter legitimate disputes over the amount of a resident's share of cost.

History. Acts 2005, No. 1273, § 1.

20-10-110. Protection of residents' personal funds — Definitions.

(a) As used in this section:

(1) "Agent" means a person who manages, uses, controls, or otherwise has legal access to a resident's income or resources that legally may be used to pay a resident's share of cost or other charges not paid by the Arkansas Medicaid program;

(2) "Long-term care facility" means a nursing home, residential care facility, post-acute head injury retraining and residential care facility, or any other facility that provides long-term medical or personal care;

(3) "Medicaid recipient" means any individual in whose behalf any person claimed or received any payment or payments from the program; and

(4) "Resident" means a person:

(A) Who resides on a permanent and full-time basis in a long-term care facility;

(B) Who is a Medicaid recipient; and

(C) Whose facility care is paid, in whole or in part, by Medicaid.

(b)(1) No long-term care facility may require a third-party guarantee of payment to the facility as a condition of admission, expedited admission, or continued stay in the facility.

(2) However, a long-term care facility may require an agent who has legal access to a resident's income or resources available to pay for facility care to sign a contract without incurring personal financial liability to provide facility payment from the resident's income or resources.

(c) An agent who guarantees payment under subdivision (b)(2) of this section shall be personally liable to the facility for payment of a resident's share of cost or other charges incurred by the resident if and to the extent that the agent uses a resident's income or resources for purposes other than the resident's facility care.

(d) Unless otherwise exempted by law or contract, a resident or his or her agent shall pay for the resident's share of cost or other charges not paid for by Medicaid.

(e) If a resident who has not been a Medicaid recipient becomes a Medicaid recipient, the long-term care facility shall make a reasonable attempt to contact the Arkansas Medicaid program to determine the resident's share of cost.

(f)(1) If a resident or his or her agent disputes the amount of share of cost owed to a long-term care facility, the resident or the agent may apply for a hearing under the rules of the Department of Human Services for a determination of the amount of share of cost owed to the long-term care facility.

(2) The hearing shall be limited to only a determination of the amount of share of cost owed to the long-term care facility and shall not result in a determination that names the person or persons responsible for the payment of that share.

(g) Any agent who knowingly violates this section is guilty of a misdemeanor and shall be punished by a fine not to exceed two thousand five hundred dollars (\$2,500) or by imprisonment not to exceed one hundred eighty (180) days, or both.

History. Acts 2005, No. 1273, § 1.

20-10-111. Disclosure statement for residential care and assisted living facilities.

(a) Each residential care and assisted living facility shall provide each prospective resident or prospective resident's representative with

a comprehensive consumer disclosure statement before the prospective resident signs an admission agreement.

(b) The disclosure statement shall include, but not be limited to:

(1) Proof of current licensure through the Office of Long-Term Care;

(2) A list of services provided by the facility, including, but not limited to:

(A) Any medication administration, assistance taking medication, or reminders to take medication that the facility may by law or regulation provide;

(B) Any assistance the facility provides with activities of daily living, such as grooming, toileting, ambulation, and bathing;

(C) The availability of transportation; and

(D) Social activities inside and outside the facility;

(3) Staffing levels or ratios required by law, including, but not limited to, those concerning:

(A) Registered nurses;

(B) Licensed nurses;

(C) Certified nurse's aides or assistants; and

(D) Other staff;

(4) Whether staff members are required to be awake while on duty and, if not, the times when they may be asleep; and

(5) Information regarding the physical plant of the facility, including, but not limited to:

(A) Whether the facility has an emergency generator and, if so, the areas of the facility powered by a generator and the length of time the generator will provide power;

(B) Whether the facility has sprinklers and, if so, the areas of the facility that have sprinklers;

(C) Whether the facility has smoke detectors and, if so, the areas in which smoke detectors are located; and

(D)(i) Whether the facility has an emergency evacuation plan.

(ii) If the facility has an emergency evacuation plan, a copy of the plan shall be provided to each prospective resident or the prospective resident's representative before the signing of an admission agreement.

(c) The facility shall update its disclosure statement no less than annually.

History. Acts 2005, No. 2002, § 1.

20-10-112. Results of a survey, inspection, or investigation prohibited in advertisements.

(a) Except as otherwise provided in this section, the results of a survey, inspection, or investigation of a long-term care facility conducted by any state or federal department or agency, including any statement of deficiencies, all findings and deficiencies cited in a statement of deficiencies, all proposed and implemented plans of correction, and all statements of interviews with individuals in connection with

any inspection or investigation, shall not be used in an advertisement, unless the advertisement includes all of the following:

- (1) The date the survey, inspection, or investigation was conducted;
- (2) A statement that a facility is required to submit a plan of correction in response to a statement of deficiencies, if applicable;
- (3) If a finding or deficiency cited in the statement of deficiencies has been corrected, a statement that the finding or deficiency has been corrected and the date that the finding or deficiency was corrected; and
- (4) A statement that the advertisement is not authorized or endorsed by the Office of Long-Term Care of the Department of Human Services or any other government agency.

(b) This section does not prohibit the results of a survey, inspection, or investigation conducted under this section from being used in an administrative proceeding or a criminal investigation or prosecution.

(c) The information required in subsection (a) of this section shall:

- (1) Be in the same font and size as the other language on or in the advertisement; and
- (2) Appear as prominently as other language used in the advertisement.

History. Acts 2015, No. 1054, § 1.

SUBCHAPTER 2 — OFFICE OF LONG-TERM CARE

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SECTION.

20-10-233. [Repealed.]

20-10-234. Relicensing bed capacity.

Publisher's Notes. Acts 1961, No. 414, codified in this subchapter as §§ 20-10-214 — 20-10-228, is also codified as § 20-9-201 et seq.

Effective Dates. Acts 1969, No. 58, § 17: Jan. 1, 1970.

Acts 1971, No. 258, § 5: became law without Governor's signature, Mar. 9, 1971. Emergency clause provided: "It is found and declared by the General Assembly of Arkansas that Act 414 of 1961, and amendments thereto, does not clearly provide the State Board of Health with the authority to license, inspect and regulate Recuperation Centers, that such intermediate health care facilities are desirable and necessary, and that there is great need for such authority to be clearly and immediately established. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the preservation of the public peace, health and safety, shall be in full force and effect from the date of its passage and approval."

Acts 1975, No. 190, § 4: Feb. 18, 1975. Emergency clause provided: "It is hereby found and determined by the General Assembly that there is an urgent need in this State for outpatient surgery centers as defined herein to relieve the severe overcrowding of hospital facilities; that such centers will serve an urgent need of the citizens of this State for additional facilities where minor surgery may be performed without the necessity of entering a hospital and incurring the much higher costs of a hospital, and that this Act should be given effect immediately to permit the establishment and operation of such facilities. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1977, No. 536, § 4: Mar. 18, 1977. Emergency clause provided: "It is hereby found and determined by the General Assembly that there is an urgent need in this State for outpatient psychiatric centers as

defined herein to relieve the severe overcrowding of hospital facilities; that such centers will serve an urgent need of the citizens of this State for additional facilities where psychiatric services may be provided without the necessity of entering a hospital and incurring the much higher costs of a hospital, and that this Act should be given effect immediately to permit the establishment and operation of such facilities. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1979, No. 28, § 15: Feb. 1, 1979. Emergency clause provided: "It is hereby found and determined by the General Assembly that there is a need for an Office of Long Term Care and that the immediate passage of this Act is necessary in order that the reorganization contemplated by this Act may be accomplished on or before July 1, 1979. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1981, No. 908, § 3: Mar. 28, 1981. Emergency clause provided: "It is hereby found and determined by the General Assembly that in order to meet the State's responsibility in assuring that residents in long term care facilities are afforded a high quality of patient care and to further enhance the effective and coordinated regulation of long term care facilities through the functions of the Office of Long Term Care the immediate passage of this Act is necessary. Therefore, an emergency is hereby declared to exist and this Act being immediately necessary for the preservation of the public peace, health, and safety shall be in full force and effect from and after its passage and approval."

Acts 1983, No. 273, § 3: Feb. 25, 1983. Emergency clause provided: "It is hereby found and determined by the General As-

sembly that the length and variety of billing forms now used by third-party carriers is an important source of administrative expense for hospitals and patients; that hospital cost containment is essential to the health, safety and welfare of the people and should be encouraged; and that a uniform billing form, if implemented without delay, will provide a significant savings in hospital costs in this State. Therefore an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1987, No. 894, § 5: emergency clause failed to pass. Emergency clause provided: "It is hereby found and determined by the General Assembly that, in order to meet the State's responsibility in assuring that residents of long term care facilities are afforded a high quality of patient care and to further enhance the effective and coordinated regulation of long term care facilities through the functions of the Office of Long Term Care, the immediate passage of the this Act is necessary. Therefore, an emergency is hereby declared to exist and this Act, being immediately necessary for the preservation of the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Identical Acts 1987 (4th Ex. Sess.), No. 4, § 6 and No. 14, § 6: July 15, 1988. Emergency clause provided: "It is hereby found and determined by the General Assembly that during recent months, certain inadequacies in the continuum of health care for the older citizens of this State have been brought to the attention of the General Assembly; that this Act is necessary to assure each citizen of this State in need of long-term care that a high quality of care at affordable cost will be provided; that the older citizenry of this State deserve the best possible care; that the immediate passage of this Act is essential to the health, welfare and safety of the citizens of the State of Arkansas and to avoid irreparable harm upon the proper administration of an essential government program. Therefore, an emergency is hereby declared to exist and this act being necessary for the preservation of the public peace, health and safety shall be in full

force and effect from and after its passage and approval."

Acts 1987 (4th Ex. Sess.), No. 16, § 3: July 15, 1988. Emergency clause provided: "It is hereby found and determined by the General Assembly that during recent months, certain inadequacies in the continuum of health care for the older citizens of this State have been brought to the attention of the General Assembly; that this Act is necessary to assure each citizen of this State in need of long-term care that a high quality of care at affordable cost will be provided; that the older citizenry of this State deserve the best possible care; that the immediate passage of this Act is essential to the health, welfare and safety of the citizens of the State of Arkansas and to avoid irreparable harm upon the proper administration of an essential government program. Therefore, an emergency is hereby declared to exist and this act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1991, No. 636, § 5: Mar. 19, 1991. Emergency clause provided: "It is hereby found and determined by the Seventy-Eighth General Assembly of the State of Arkansas that applicants and licensees for long-term care facilities and administrators licenses must now go to Pulaski County Circuit Court in order to appeal decisions of the Office of Long-Term Care and do it within fifteen (15) days of the decision; that this makes it terribly inconvenient and costly for licensees and administrators who must drive long distances to reach Pulaski County and take off days to attend the court hearings; and that these circumstances create an inefficient and inequitable situation which must be corrected immediately. Therefore, in order to alleviate this inefficient system of appeals, an emergency is hereby declared to exist, and this act being necessary for the immediate preservation of the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Acts 1991, No. 922, § 28: July 1, 1991. Emergency clause provided: "It is hereby found and determined by the Seventy-Eighth General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness

of this Act on July 1, 1991 is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1, 1991 could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 1991."

Acts 1991, No. 1129, § 33: July 1, 1991. Emergency clause provided: "It is hereby found and determined by the Seventy-Eighth General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness of this Act on July 1, 1991 is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1, 1991 could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 1991."

Acts 1997, No. 1025, § 6: Apr. 2, 1997. Emergency clause provided: "It is hereby found and determined by the General Assembly that this act excludes certain transitional pediatric rehabilitation facilities from the permit of approval process; and that this act is immediately necessary to allow such facilities to proceed without delay. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 2001, No. 91, § 2: Feb. 6, 2001. Emergency clause provided: "It is found and determined by the General Assembly that maintaining a safe and stable environment for the elderly and infirm is a duty of this State; that the immediate passage and implementation of this act is necessary to protect the health and welfare of the elderly and infirm who are currently being well cared for in private homes and are at imminent risk of being unjustly uprooted from their current residence; and that the mental trauma, disorientation, and possible physical complications that would result from their relocation would cause them to suffer irreparable harm. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 2005, No. 2191, § 11: Apr. 13, 2005. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that various long-term care facilities are operating in this state without having obtained a license; that there is no state oversight or protection for the vulnerable residents in these facilities; and that there is no way of ensuring that the facilities properly treat and protect these residents under state long-term care laws. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

Identical Acts 2016 (3rd Ex. Sess.), Nos. 2 and 3, § 129: May 23, 2016. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that this act revises the

membership and duties of certain agencies, task forces, committees, and commissions and repeals other governmental entities; that these revisions and repeals of governmental entities impact the expenses and operations of state government; and that the provisions of this act should become effective as soon as possible to allow for implementation of the new provisions in advance of the upcoming fiscal year. Therefore, an emergency is

declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

20-10-201. Legislative intent.

The General Assembly declares that this act is necessary to assure the effective and coordinated regulation of long-term care facilities and long-term care facility administrators within an orderly organizational structure of government at such levels of economy as are consistent with the state's policy of promoting high standards of quality in the services and to eliminate overlapping and duplication of effort.

History. Acts 1979, No. 28, § 2; A.S.A. 1947, § 82-2217.

Publisher's Notes. Acts 1979, No. 28, § 3, provided that it is the intent of the General Assembly to provide for an orderly transfer of powers, duties, and functions relative to the regulation of long-term care facilities and long-term care facility administrators vested in the Department of Health to the Office of Long-

Term Care with a minimum of disruption of governmental services and functions and with a minimum of expense. The section further provided that, towards that end, Acts 1979, No. 28, § 3, should be liberally construed.

Meaning of "this act". Acts 1979, No. 28, codified as §§ 20-10-101, 20-10-201 — 20-10-206, 20-10-208 — 20-10-210, 20-10-301 — 20-10-303 [repealed].

20-10-202. Creation.

There is created an Office of Long-Term Care within the appropriate division as determined by the Director of the Department of Human Services. The head of the office shall be appointed by the director.

History. Acts 1979, No. 28, § 4; A.S.A. 1947, § 82-2219.

20-10-203. Powers and duties.

(a) The Office of Long-Term Care is designated as the unit of state government primarily responsible for the inspection, regulation, and licensure of long-term care facilities and the regulation and licensure of long-term care facility administrators.

(b) The office may promulgate such rules and regulations not inconsistent with this chapter as it shall deem necessary or desirable to properly and efficiently carry out the purposes and intent of this chapter.

History. Acts 1969, No. 58, § 13; 1979, No. 28, § 4; A.S.A. 1947, §§ 82-2213, 82-2219.

20-10-204. Notice of violation.

(a) If upon inspection or investigation the Office of Long-Term Care determines that a licensed long-term care facility is in violation of any federal or state law or regulation pertaining to Title XIX Medicaid certification or licensure, the office shall promptly serve by certified mail or other means that gives actual notice, a notice of violation upon the licensee when the violation is a classified violation as described in § 20-10-205.

(b) Each notice of violation shall:

(1) Be prepared in writing;

(2) Specify the:

(A) Exact nature of the classified violation;

(B) Statutory provision or specific rule alleged to have been violated;

(C) Facts and grounds constituting the elements of the classified violation; and

(D) Amount of civil penalty or other administrative remedy, if any, imposed by the Director of the Department of Human Services; and

(3)(A) Inform the licensee of the right to a hearing under § 20-10-208 when administrative remedies or civil penalties are imposed.

(B) Any hearing conducted under this chapter shall conform to the Arkansas Administrative Procedure Act, § 25-15-201 et seq., and rules of the Department of Human Services promulgated under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

History. Acts 1979, No. 28, § 4; 1981, No. 908, § 1; A.S.A. 1947, § 82-2219; Acts 1987, No. 894, § 3; 1988 (4th Ex. Sess.), No. 4, § 1; 1988 (4th Ex. Sess.), No. 14, § 1; 2005, No. 898, § 2.

U.S. Code. Title XIX referred to in this section is codified as 42 U.S.C. § 1396 et seq.

CASE NOTES

In General.

Jury verdict in favor of nursing home facility on the medical malpractice and wrongful death claims did not exonerate it from wrongdoing under the Arkansas Long-Term Care Facilities Code, § 20-10-224, because, even though the causes of action were tried together, the resident's-rights claim under § 20-10-1209(a)(1) was a statutory claim separate and apart from the common-law claim of ordinary negligence, and the jury was entitled to reach

conflicting results in relation to those claims; further, there was sufficient evidence that the facility violated the resident's rights under the statute where the resident was left in her own urine at times, and was not provided with adequate care or treatment for pressure sores, weight loss, contractures, and other injuries from an accident in the facility van. *Health Facilities Mgmt. Corp. v. Hughes*, 365 Ark. 237, 227 S.W.3d 910 (2006) (decision under prior law).

20-10-205. Classification of violations.

(a) The Office of Long-Term Care shall promulgate rules and regulations specifying classified violations in accordance with this section.

(b) The notice of violation issued to a long-term care facility by the Director of the Office of Long-Term Care shall be classified according to the nature of the violation and shall indicate the classification on the face of the notice as follows:

(1) Class A violations create a condition or occurrence relating to the operation and maintenance of a long-term care facility resulting in death or serious physical harm to a resident or creating a substantial probability that death or serious physical harm to a resident will result therefrom;

(2) Class B violations create a condition or occurrence relating to the operation and maintenance of a long-term care facility which directly threatens the health, safety, or welfare of a resident;

(3) Class C violations shall relate to administrative and reporting requirements that do not directly threaten the health, safety, or welfare of a resident; and

(4)(A) Class D violations shall relate to the timely submission of statistical and financial reports to the office.

(B) The failure to timely submit a statistical or financial report shall be considered a separate Class D violation during any month or part of a month of noncompliance.

(C) In addition to any civil penalty which may be imposed, the director is authorized, after the first month of a Class D violation, to withhold any further reimbursement to the long-term care facility until the statistical and financial report is received by the office.

History. Acts 1979, No. 28, § 4; 1981, 1988 (4th Ex. Sess.), No. 4, § 2; 1988 (4th No. 908, § 1; A.S.A. 1947, § 82-2219; Acts Ex. Sess.), No. 14, § 2.

20-10-206. Civil penalties.

(a)(1) In the case of a Class A violation, the following civil penalties shall be assessed by the Director of the Office of Long-Term Care against the long-term care facility. In Class B, Class C, or Class D violations, the director, in his or her discretion, may assess the following civil penalties or may allow a specified period of time for correction of the violation:

(A)(i) Class A violations are subject to a civil penalty not to exceed two thousand five hundred dollars (\$2,500) for the first violation.

(ii) A second Class A violation occurring within a six-month period shall be subject to a civil penalty of five thousand dollars (\$5,000).

(iii) The third Class A violation occurring within a six-month period from the first violation shall result in proceedings being commenced for termination of the facility's Medicaid agreement and may result in proceedings being commenced for revocation of licensure of the facility;

(B)(i) Class B violations are subject to a civil penalty not to exceed one thousand dollars (\$1,000).

(ii) A second Class B violation occurring within a six-month period shall be subject to a civil penalty of two thousand dollars (\$2,000).

(iii) A third Class B violation occurring within a six-month period from the first violation shall result in proceedings being commenced for termination of the facility's Medicaid agreement and may result in proceedings being commenced for revocation of the licensure of the facility;

(C) Class C violations are subject to a civil penalty to be set by the director in an amount not to exceed five hundred dollars (\$500) for each violation; and

(D) Class D violations are subject to a civil penalty to be set by the director in an amount not to exceed two hundred fifty dollars (\$250) for each violation.

(2) Each subsequent Class C and Class D violation within a six-month period from the last violation shall subject the facility to a civil penalty double that of the preceding violation until a maximum of one thousand dollars (\$1,000) per violation is reached.

(3) In no event may the aggregate fines assessed for violations determined in any one (1) month exceed five thousand dollars (\$5,000).

(b) In determining whether a civil penalty is to be imposed and in fixing the amount of the penalty to be imposed, or if a specified period of time shall be allowed for correction, the following factors shall be considered:

(1) The gravity of the violation, including the probability that death or serious physical harm to a resident will result or has resulted;

(2) The severity and scope of the actual or potential harm;

(3) The extent to which the applicable statutes or regulations were violated;

(4) The "good faith" exercised by the licensee. Indications of good faith include, but are not limited to:

(A) Awareness of the applicable statutes and regulations and reasonable diligence in securing compliance;

(B) Prior accomplishments manifesting the licensee's desire to comply with the requirements;

(C) Efforts to correct; and

(D) Any other mitigating factors in favor of the licensee;

(5) Any relevant previous violations committed by the licensee; and

(6) The financial benefit to the licensee of committing or continuing the violation.

(c) Assessment of a civil penalty provided by this section shall not affect the right of the Office of Long-Term Care to take such other action as may be authorized by law or regulation.

History. Acts 1979, No. 28, § 4; 1981, 1987, No. 894, §§ 1, 2; 1988 (4th Ex. No. 908, § 1; A.S.A. 1947, § 82-2219; Acts Sess.), No. 4, § 3; 1988 (4th Ex. Sess.), No.

14, § 3.

20-10-207. Notification to media of violations.

(a) When the Office of Long-Term Care's appropriate division, as determined by the Director of the Department of Human Services, finds, upon inspection and investigation, that any nursing home or residential care facility has committed two (2) violations constituting Class A or Class B violations as defined in § 20-10-205 during any twelve-month period, the office shall notify the various news media within the county wherein the nursing home or residential care facility is located and shall advise the media that a complete record of the inspection and investigation will be available for public inspection at the office.

(b) However, no information shall be made available which will identify any resident, the family of any resident of the nursing home, the residential care facility, or any person who has filed a complaint against a nursing home or against an administrator or any personnel of a nursing home or residential care facility, except in cases of criminal or civil litigation.

(c) When the office finds, upon inspection and investigation, that any long-term care facility has committed a Class A or Class B violation, following final determination of the matter on administrative appeal, the long-term care facility administrator shall cause copies of the notice of violation as prepared by the office to be posted on the front entry to the facility to be visible from the interior. The notice shall be posted within seven (7) days of the final determination of the matter on administrative appeal and shall remain posted for a period of not less than sixty (60) days.

(d) The notice of violation shall meet the following requirements:

(1) The notice shall read:

(A) "NOTICE

(B) "This facility has been cited with a CLASS A or B VIOLATION.

(C) "Pursuant to § 20-10-205, 'Class A violations create a condition or occurrence relating to the operation and maintenance of a long-term care facility resulting in death or serious physical harm to a resident or creating a substantial probability that death or serious physical harm to a resident will result therefrom. Class B violations create a condition or occurrence relating to the operation and maintenance of a long-term care facility which directly threatens the health, safety, or welfare of a resident.

(D) "Date of violation: _____

(E) "Nature of violation: _____

(F) "Further information can be obtained from the Office of Long-Term Care at (____ number ____).

(G) "This notice shall remain posted for a period not less than sixty (60) days from (date) to (date)."

(2) The notice shall be printed in accordance with the following specifications:

(A) The notice shall be eight and one-half inches by eleven inches (8 ½" x 11") in size;

(B) The notice shall be printed on a white background;

(C) Subdivision (d)(1)(A) of this section shall be printed in red ink in all capital letters at the top center of the page in 48-point boldface type;

(D) Subdivision (d)(1)(B) of this section shall be printed in black ink in 18-point type, except for the words "CLASS A or CLASS B VIOLATION", which shall be printed in red ink, in capital letters, in 24-point boldface type;

(E) Subdivision (d)(1)(C) of this section shall be printed in black ink with 10-point type. This paragraph shall be indented and boxed;

(F) Subdivisions (d)(1)(D) and (d)(1)(E) of this section shall be underlined and printed in black ink with 18-point type;

(G) Subdivisions (d)(1)(F) and (G) of this section shall be printed in 18-point boldface type; and

(H) The entries to be made shall be written in indelible red ink.

(e) A notice of correction may be posted by the facility administrator upon receipt from the office, provided that the notice does not obscure the notice of violation. Posting of the notice of correction shall not reduce the amount of time required for the posting of the notice of violation set forth in subsection (c) of this section.

(f)(1) The ombudsman of the Division of Aging, Adult, and Behavioral Health Services of the Department of Human Services shall be furnished with each final copy of a survey upon completion by the office.

(2)(A) The ombudsman shall prepare a one-page form letter which specifically states whether the facility was found in compliance or out of compliance during the most recent annual survey. In addition, the letter shall include the same information from the previous three (3) annual surveys.

(B) The letter shall be considered separately from the survey process and shall not be admissible as evidence in any proceeding by either party in litigation arising from licensure or certification of long-term care facilities.

(C) Copies of the letter shall be furnished by the office to the facility administrator and the Attorney General.

(g)(1) A long-term care facility required to be licensed under this subchapter shall post in a conspicuous place, readily accessible to residents and visitors, the final certification survey following final administrative determination as defined by regulation of the statement of deficiencies and plans-of-correction survey report received by the facility.

(2) With the survey report, the facility shall post the summary letter prepared by the ombudsman.

(3) The survey report and letter shall remain posted until the next survey report is received by the facility.

(h) Failure to post a notice of violation as required by subsection (c) of this section shall be considered a Class C violation under § 20-10-205

for which civil penalties set forth in § 20-10-206 may be imposed, with each day of noncompliance constituting a separate offense. Otherwise, the failure to comply with the requirements of this section by a long-term care facility or facility administrator shall be considered a Class C violation under § 20-10-205 for which civil penalties set forth in § 20-10-206 may be imposed.

History. Acts 1983, No. 468, § 1; A.S.A. 1947, § 82-2219.1; Acts 1988 (4th Ex. Sess.), No. 16, § 1; 1999, No. 1539, § 3; 2017, No. 913, § 56.

Amendments. The 2017 amendment

substituted “Division of Aging, Adult, and Behavioral Health Services” for “Division of Aging and Adult Services” in (f)(1); and made a stylistic change.

20-10-208. Hearings.

(a)(1) A licensee may contest an assessment of a civil penalty or any administrative remedy imposed by the Office of Long-Term Care by sending a written request for a hearing to the Director of the Department of Human Services.

(2) Requests for hearings shall be received by the Director of the Department of Human Services within sixty (60) days after receipt by the licensee of the notice of violation and the assessment of any civil penalty or any administrative remedy imposed by the office.

(b)(1) The Director of the Department of Human Services shall assign the appeal to a fair and impartial hearing officer who shall not be a full-time employee of the Department of Human Services.

(2) The hearing officer shall preside over the hearing and make findings of fact and conclusions of law in the form of a recommendation to the Director of the Department of Human Services.

(3) The Director of the Department of Human Services shall review any recommendation and make the final decision. He or she:

(A) May approve the recommendation; or

(B) May for good cause:

(i) Modify the recommendation in whole or in part; or

(ii)(a) Remand the recommendation for further proceedings as directed by him or her.

(b) If the recommendation is remanded, the hearing officer shall conduct further proceedings as directed by the Director of the Department of Human Services and shall submit an amended recommendation to the Director of the Department of Human Services.

(4) If the Director of the Department of Human Services modifies a recommendation, in whole or in part, or if the Director of the Department of Human Services remands the decision, he or she shall state in writing at the time of the remand or modification all grounds for the remand or modification, including statutory, regulatory, factual, or other grounds.

(5) The modification or approval of a recommendation by the Director of the Department of Human Services shall be the final agency action as provided by the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(c)(1)(A) The department shall commence the hearing within forty-five (45) days of receipt of the request for hearing, and the hearing officer shall notify the Director of the Office of Long-Term Care of the date, time, and place of the hearing.

(B) The notification shall be in writing and shall be sent at least twenty (20) days before the hearing date.

(C)(i) The licensee may agree in writing to waive the requirement that the department commence the hearing within forty-five (45) days.

(ii) If the licensee waives the time limit under subdivision (c)(1)(C)(i) of this section, the hearing officer shall commence the hearing at the time agreed to by the parties.

(2) The hearing officer shall issue a recommended decision within ten (10) working days after the close of the hearing, the receipt of the transcript, or the submission of post-trial briefs requested or approved by the hearing officer, whichever is latest.

(3) Unless the Director of the Department of Human Services acts on the recommendation of the hearing officer within sixty (60) days of receipt of the recommendation, the recommendation of the hearing officer shall be final.

(4) Assessments shall be paid to the office within thirty (30) working days of receipt of the notice of violation or within thirty (30) working days of receipt of the final agency action in contested cases, unless the matter has been timely appealed to circuit court.

(5) Facilities failing to pay assessed civil penalties shall be subject to a corresponding reduction in the succeeding Medicaid vendor payment in lieu of nonpayment.

(d) Except to the extent that it is inconsistent with federal law or regulation, a written request for a hearing shall stay until denied by the Director of the Department of Human Services any enforcement action imposed by the office pending the hearing and the final decision of the Director of the Department of Human Services.

(e) Any party subject to appear before a hearing officer may appear and be heard at any proceeding prescribed in this section or may be represented by an attorney or other designated representative, or both.

(f)(1) Upon written request of a licensee, the department shall provide copies of all documents, papers, reports, and other information gathered through inspection or survey that relate to the matter being appealed.

(2) The disclosure shall be made no later than ten (10) working days before a scheduled hearing date or by the date specified by the hearing officer.

History. Acts 1979, No. 28, § 4; 1981, No. 908, § 1; A.S.A. 1947, § 82-2219; Acts 2005, No. 898, § 3; 2011, No. 1139, § 3.

CASE NOTES

Final Decision.

Although the hearing officer's recommendation was submitted to the deputy director, there was nothing in the record to indicate that the director made any final determination with respect to the hearing officer's recommendation; this

section did not contain a provision for a decision to become final due to inaction. *Waldron Nursing Ctr., Inc. v. Ark. Dep't of Human Servs.*, 82 Ark. App. 268, 105 S.W.3d 781 (2003) (decision under prior law).

20-10-209. Disposition of funds.

(a)(1) There is established on the books of the Treasurer of State, Auditor of State, and the Chief Fiscal Officer of the State a trust fund to be known as the "Long-Term Care Trust Fund".

(2) The fund shall consist of all moneys and interest received from the imposition of civil penalties levied by the state on long-term care facilities found to be out of compliance with the requirements of federal or state law or regulations, there to be administered by the Director of the Department of Human Services solely for the protection of the health or property of residents of long-term care facilities, including, but not limited to, the payment for the costs of relocation of residents to other facilities, maintenance and operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost.

(b) Funds from the Long-Term Care Trust Fund may also be administered by the Director of the Department of Human Services for programs or uses that, in the determination of the Director of the Office of Long-Term Care, enhance the quality of life for long-term care facility residents through the adoption of principles and building designs established by the Eden Alternative, Inc. or Green House Project programs or other means.

History. Acts 1979, No. 28, § 4; 1981, No. 908, § 1; A.S.A. 1947, § 82-2219; Acts 1988 (4th Ex. Sess.), No. 4, § 4; 1988 (4th Ex. Sess.), No. 14, § 4; 2007, No. 193, § 1.

20-10-210. Information received by Office of Long-Term Care confidential.

(a) Except in cases of civil or criminal litigation or as permitted in subsection (b) of this section, information received by the Office of Long-Term Care, through inspection or otherwise, shall not be disclosed publicly, in administrative appeals or otherwise, in such a manner as to identify long-term care facility residents, their families, or persons filing complaints against a long-term care facility.

(b) Information received or generated by the office, including surveyors' notes, documents, photographs, or other materials gathered, generated, or used by the surveyors in their survey or investigation of a founded complaint, shall be made available to the long-term care facility that is the subject of the survey or investigation upon the completion of the investigation or survey. However, no information that

reveals the identity or tends to reveal the identity of any complainant may be disclosed.

History. Acts 1979, No. 28, § 6; A.S.A. 1947, § 82-2221; Acts 1999, No. 1539, § 1; 2001, No. 1774, § 1.

RESEARCH REFERENCES

Ark. L. Rev. Watkins, Access to Public Records Under the Arkansas Freedom of Information Act, 37 Ark. L. Rev. 741.

Legislation, 2001 Arkansas General Assembly, Public Health and Welfare, 24 U. Ark. Little Rock L. Rev. 557.

U. Ark. Little Rock L. Rev. Survey of

20-10-211. Facilities — Regulation of staffing.

(a) The agency responsible for licensure and certification of long-term care facilities shall promulgate appropriate rules and regulations prescribing minimum staffing requirements for all long-term care facilities in the state. The agency shall conform to the requirements of the Arkansas Administrative Procedure Act, § 25-15-201 et seq., and other appropriate state laws in promulgating and placing rules and regulations into effect.

(b) Failure to comply with the rules and regulations promulgated by the appropriate agency pursuant to subsection (a) of this section shall be cause for revocation or suspension of the license or certification of any long-term care facility.

(c)(1) This section shall apply only to licensed nursing homes.

(2) This section shall not be applicable to any facility of the Division of Developmental Disabilities Services of the Department of Human Services or to any other facility operated by the State of Arkansas or any agency of the state.

History. Acts 1979, No. 169, §§ 1-3; A.S.A. 1947, §§ 82-2223 — 82-2225.

20-10-212. Appeal from denial, suspension, or revocation of license.

(a) Any applicant or licensee who is aggrieved by any decision of the Office of Long-Term Care with respect to the denial, suspension, or revocation of any long-term care facility license or long-term care facility administrator license or other final decision of the office with respect to standards of construction, operation, or maintenance of long-term care facilities or long-term care facility personnel or employees may appeal within thirty (30) days the decision of the office to the Pulaski County Circuit Court or to the circuit court of any county in which the applicant or licensee resides or does business.

(b) Pending determination of the matter on appeal, the status quo of the applicant or licensee shall be preserved.

History. Acts 1969, No. 58, § 12; A.S.A. 1947, § 82-2212; Acts 1991, No. 636, § 1.

20-10-213. Definitions for §§ 20-10-213 — 20-10-228.

As used in this section and §§ 20-10-214 — 20-10-228:

- (1) “Department” means the Department of Human Services;
- (2) “Director” means the Director of the Office of Long-Term Care;
- (3) “Federal act” means the Hospital Survey and Construction Act, Pub. L. No. 79-725, as amended;
- (4)(A)(i) “Institution” means a place for the diagnosis, treatment, or care of two (2) or more persons not related to the proprietor’s suffering from illness, injury, or deformity or where obstetrical care or care of the aged, blind, or disabled is rendered over a period exceeding twenty-four (24) hours.
 - (ii) “Institution” also includes an outpatient surgery center and an alcohol and drug abuse treatment center.
- (B) No establishment operated by the United States Government or an agency thereof is within this definition;
- (5)(A) “Long-term care facility” means any building, structure, agency, institution, or other place for the reception, accommodation, board, care, or treatment of more than three (3) unrelated individuals who because of age, illness, blindness, disease, or physical or mental infirmity are unable to sufficiently or properly care for themselves and where a charge is made for that reception, accommodation, board, care, or treatment.
 - (B) “Long-term care facility” does not include:
 - (i) The offices of private physicians and surgeons;
 - (ii) Hospitals;
 - (iii) Recuperation centers;
 - (iv) Supervised or supported living apartments, group homes, family homes, or developmental day treatment clinics for individuals with developmental disabilities operated by providers licensed by the Division of Developmental Disabilities Services of the Department of Human Services;
 - (v) Institutions operated by the United States Government;
 - (vi) Separate living arrangements that do not involve monitoring the activities of the residents while on the premises of the institution or facility to ensure the residents’ health, safety, or well-being and that do not involve the institution or facility’s being aware of the residents’ general whereabouts; or
 - (vii) Hospices;
- (6) “Medical facility” means a diagnostic or diagnostic and treatment center, a rehabilitation facility, or a nursing home as these terms are defined in the federal act, and any other medical facility for which federal aid may be authorized under federal law;
- (7) “Office” means the Office of Long-Term Care; and
- (8) “Surgeon General” means the United States Surgeon General.

History. Acts 1961, No. 414, § 2; 1971, No. 258, § 1; 1975, No. 190, §§ 1, 2; 1977, No. 536, §§ 1, 2; 1985, No. 980, §§ 1, 2; A.S.A. 1947, § 82-328; Acts 1993, No. 909, § 1; 1993, No. 1090, § 2; 1993, No. 1102, § 1; 1997, No. 1028, § 2; 2001, No. 91, § 1; 2001, No. 465, § 1; 2005, No. 2191, § 4; 2017, No. 540, § 38.

A.C.R.C. Notes. Acts 1997, No. 1028, § 1, provided: “Legislative Findings and Intent. It is the intent of this act to provide for the protection, safety and quality

of care of elderly and disabled Arkansans by allowing only long-term care facilities that have been licensed, inspected and regulated by the state to operate.”

Amendments. The 2017 amendment repealed (1).

U.S. Code. The Hospital Survey and Construction Act referred to in this section has, for the most part, been eliminated from the United States Code. For remaining provisions, see 48 U.S.C. § 1666 and 42 U.S.C. § 291.

RESEARCH REFERENCES

U. Ark. Little Rock L.J. Survey of Arkansas Law, Insurance, 1 U. Ark. Little Rock L.J. 210.

Survey of Legislation, 2001 Arkansas General Assembly, Public Health and Welfare, 24 U. Ark. Little Rock L. Rev. 557.

CASE NOTES

Cited: *Raney v. Raulston*, 238 Ark. 875, 385 S.W.2d 651 (1965).

20-10-214. Penalties for §§ 20-10-213 — 20-10-228.

(a) Any person, partnership, association, or corporation establishing, conducting, managing, or operating any institution or facility or any combination of separate entities working in concert within the meaning of §§ 20-10-213 — 20-10-228 without first obtaining a license therefor as provided or violating any provision of §§ 20-10-213 — 20-10-228 or regulation lawfully promulgated under §§ 20-10-213 — 20-10-228 shall be guilty of a violation.

(b) Upon conviction, the person, partnership, association, or corporation shall be liable for a fine of not less than one hundred dollars (\$100) nor more than five hundred dollars (\$500) for the first offense nor more than one thousand dollars (\$1,000) for each subsequent offense.

(c) Each day that the institution shall operate after a first conviction shall be considered a subsequent offense.

History. Acts 1961, No. 414, § 27; A.S.A. 1947, § 82-353; Acts 1993, No. 1238, § 5; 2005, No. 1994, § 110.

20-10-215. Injunction for §§ 20-10-213 — 20-10-228.

The Department of Human Services may sue in the name of the state any person, partnership, association, or corporation in order to enjoin the establishing, conducting, managing, or operating of any institution or facility, or any combination of separate entities working in concert within the meaning of §§ 20-10-213 — 20-10-228, without the person’s first having secured a license therefor.

History. Acts 1961, No. 414, § 26; A.S.A. 1947, § 82-352; Acts 1993, No. 1238, § 6.

20-10-216. Powers and duties of Department of Human Services.

(a) In carrying out §§ 20-10-213 — 20-10-228, the Department of Human Services is empowered and directed to:

(1) Require such reports, make such inspections and investigations, and prescribe and enforce such reasonable rules and regulations as it finds necessary to effectuate §§ 20-10-213 — 20-10-228;

(2) Provide methods of administration and appoint a director and other personnel of the department;

(3) Procure and pay for the temporary services of experts or consultants on a fee-for-service basis;

(4) Enter into agreements for the utilization of the facilities and services of other departments, agencies, and institutions, public and private;

(5) Accept on behalf of the state and deposit with the Treasurer of State any grant, gift, or contribution of funds made to assist in meeting the cost of carrying out §§ 20-10-213 — 20-10-228 and expend such funds accordingly;

(6) Make an annual report to the Governor on activities and expenditures made pursuant to §§ 20-10-213 — 20-10-228;

(7) Procure the services of an attorney to assist the department in any legal work involved in carrying out the duties of the department and pay for the services on a fee-for-service or retainer basis; and

(8) Accept a certificate made by an individual's physician that the individual is in need of nursing home care or that he or she can provide for himself or herself.

(b) The department shall adopt, promulgate, and enforce such rules, regulations, and standards as may be necessary for the accomplishment of §§ 20-10-213 — 20-10-228. The rules, regulations, and standards shall be modified, amended, or rescinded by the department as may be in the public interest.

History. Acts 1961, No. 414, §§ 4, 28; 1983, No. 273, § 1; A.S.A. 1947, §§ 82-330, 82-354; Acts 2005, No. 2191, § 5.

20-10-217. Construction program — Survey and planning activities.

(a) The Department of Human Services is empowered and directed to make an inventory of existing medical facilities including public, nonprofit, and proprietary medical facilities, survey the need for construction of medical facilities, and, on the basis of the inventory and survey, develop a program for the construction of such public and other nonprofit medical facilities as will, in conjunction with existing facili-

ties, afford the necessary physical facilities for furnishing adequate medical facility services to the people of the state in accordance with the regulations prescribed by the Hospital Survey and Construction Act, Pub. L. No. 79-725.

(b) The construction program shall provide, in accordance with regulations prescribed by the federal act, for adequate medical facilities for the people of the state, and insofar as possible shall provide for their distribution throughout the state in such manner as to make all types of medical facility services reasonably accessible to all persons in the state.

History. Acts 1961, No. 414, §§ 9, 10;
A.S.A. 1947, §§ 82-335, 82-336.

CASE NOTES

Cited: Raney v. Raulston, 238 Ark. 875,
385 S.W.2d 651 (1965).

20-10-218. Construction program — Federal funds for surveying and planning.

(a) The Department of Human Services may make application to the United States Surgeon General for, and receive, federal funds to assist in carrying out the survey and planning activities provided for in § 20-10-217.

(b) The funds shall be deposited with the Treasurer of State as a trust fund designated "Hospital and Medical Facility Survey and Planning Fund", which shall be kept separate and apart from all public funds of the state and shall be available to the department for expenditure in carrying out the survey and planning activities provided.

(c) Any funds received and not expended for such purposes shall be repaid to the United States Treasury.

(d) Warrants for all payments from the fund shall bear the signature of the Director of the Department of Human Services or his or her agent.

History. Acts 1961, No. 414, § 11;
A.S.A. 1947, § 82-337.

20-10-219. Construction program — State plan.

(a)(1) The Department of Human Services shall prepare and submit to the United States Surgeon General a state plan which shall include the medical facilities construction program developed as provided in this subchapter. The plan shall provide for the establishment, administration, and operation of medical facilities construction activities in accordance with the requirements of the federal act and regulations under the federal act.

(2) The state plan shall also set forth the relative need for the several projects included in the construction program determined in accordance with regulations prescribed by the federal act and provide for the construction, insofar as financial resources available for construction and for maintenance and operation permit, in the order of relative need.

(b) Before the submission of the plan to the United States Surgeon General, the department shall give adequate publicity to a general description of all the provisions proposed to be included therein and hold a public hearing at which all persons or organizations with a legitimate interest in the plan may be given an opportunity to express their views.

(c) After approval of the plan by the United States Surgeon General, the department shall cause to be published a general description of the provisions thereof in at least one (1) newspaper having general circulation in each county in the state and shall make the plan, or a copy thereof, available upon request to all interested persons or organizations.

(d) The department shall review the construction program, submit to the United States Surgeon General any modifications of the program which it may find necessary, and may submit to the United States Surgeon General modifications of the state plan not inconsistent with the requirements of the federal act.

History. Acts 1961, No. 414, §§ 12, 14;
A.S.A. 1947, §§ 82-338, 82-340.

20-10-220. Construction program — Application for funds.

(a) Applications for medical facilities construction projects for which federal funds are requested shall be submitted to the Department of Human Services and may be submitted by the state or any political subdivision thereof or by any public or other nonprofit agency authorized to construct and operate a medical facility.

(b) However, no application for a diagnostic or treatment center shall be approved unless the applicant is:

(1) The state, a political subdivision, or a public agency; or

(2) A person, corporation, or association which owns and operates a nonprofit hospital.

(c) Each application for a construction project shall conform to federal and state requirements.

(d) If after affording reasonable opportunity for development and presentation of applications in the order of relative need the department finds that a project application complies with the requirements of subsection (a) of this section and is otherwise in conformity with the state plan, then it shall approve the application and shall recommend and forward it to the United States Surgeon General.

(e) The department by regulation shall provide an opportunity for fair hearing and appeal to every applicant who is dissatisfied with any action regarding an application.

History. Acts 1961, No. 414, §§ 15, 16;
A.S.A. 1947, §§ 82-341, 82-342.

20-10-221. Construction program — Payment of installments.

The Department of Human Services shall cause to be inspected each construction project approved by the United States Surgeon General. If the inspection warrants, the department shall certify to the United States Surgeon General that work has been performed upon the project or that purchases have been made in accordance with the approved plans and specifications and that payment of an installment of federal funds is due the applicant.

History. Acts 1961, No. 414, § 17;
A.S.A. 1947, § 82-343.

20-10-222. Construction program — Federal funds.

(a) The Department of Human Services is empowered to receive federal funds in behalf of and transmit them to such applicants.

(b) Money received from the United States Government for a construction project shall be deposited with the Treasurer of State as a trust fund designated "Hospital and Medical Facilities Construction Fund". The fund shall be separate and apart from all public funds of the state and shall be used solely for payments due to applicants for work performed or purchases made in carrying out approved projects.

(c) Warrants for all payments from the fund shall bear the signature of the Director of the Office of Long-Term Care or his or her agent.

(d) The procedure provided in this section for the receipt and disbursement of such funds is not intended to deprive any applicant from receiving federal payments directly if, for any reason, the department or the Treasurer of State is not authorized to receive and transmit federal payments for certain construction projects to certain applicants.

History. Acts 1961, No. 414, § 18; Medical Facilities Construction Fund, referred to in this section, no longer exists.
A.S.A. 1947, § 82-344.

Publisher's Notes. The Hospital and See title 19, chapters 5 and 6.

20-10-223. Minimum standards for institutions.

(a) The Department of Human Services shall require institutions which receive federal aid for construction under the state plan to comply with such minimum standards prescribed by the department as may be promulgated in accordance with the federal act and federal rules and regulations.

(b) An institution, or the governing body thereof, shall comply with such minimum standards as may be prescribed by the department under the authority of this section even though federal aid may not be sought or received under §§ 20-10-213 — 20-10-228.

History. Acts 1961, No. 414, § 13;
A.S.A. 1947, § 82-339.

20-10-224. License required — Administration by Department of Human Services.

(a) No long-term care facility or related institution shall be established, conducted, or maintained in this state without obtaining a license.

(b)(1) By properly promulgating rules and regulations, the Department of Human Services may provide for the issuance of provisional long-term care facility licenses and long-term care facility licenses, including the licensure of facilities with specialized wings, units, or rooms for dementia residents, those suffering from Alzheimer's disease, and other related conditions.

(2) The licenses shall be effective on a state fiscal year basis and shall expire June 30 of each year, subject to revocation and to annual renewal.

(3)(A) If issued, a provisional license shall be effective upon submission of the application for licensure to the Office of Long-Term Care.

(B) The provisional license shall remain in effect until the issuance of the long-term care facility license.

(c)(1) Applicants for long-term care facility licensure shall file applications under oath with the office.

(2) Applications shall be signed by the administrator or the owner of the facility.

(3) Applications shall set forth the full name and address of the facility for which licensure is sought and additional information as the office may require, including affirmative evidence of ability to comply with standards, rules, and regulations as may be lawfully prescribed.

(d) No license shall be issued or renewed for any long-term care facility unless the applicant has included in the application the name and such other information required for licensure and disclosure. This requirement, as well as any other requirement determined appropriate by the department, shall be in accordance with the guidelines provided by the department.

(e)(1) Whenever ownership of controlling interest in the operation of a facility is sold by the person or persons named in the license to any other person or persons, the buyer shall obtain a license to operate the facility. The buyer shall notify the department of the sale and apply for a license at least thirty (30) days before the completed sale.

(2) Except as provided by the Arkansas Long-Term Care Facility Receivership Law, § 20-10-901 et seq., the seller shall notify the department at least thirty (30) days before the completed sale. The seller shall remain responsible for the operation of the facility until such time as a license is issued to the buyer.

(3) The buyer shall be subject to any plan of correction submitted by the previous licensee and approved by the department.

(4) The seller shall remain liable for all penalties assessed against the facility which are imposed for violations or deficiencies occurring before sale of ownership or operational control.

(5) Before approval of the application for licensure of the buyer, the department shall consider and may deny a license based upon the following:

(A) Whether the administrator, officers, directors, or partners have ever been convicted of a felony;

(B) Whether, within twelve (12) months before the license application, any facility or facilities owned or operated by the applicant or applicants have been found, after final administrative decision, to have committed a Class A violation;

(C) Whether during the three (3) years before the application, the applicant or applicants have had a license revoked; or

(D) Whether the applicant or applicants have demonstrated to the satisfaction of the department that any other facility owned, operated, or administered by the applicant or applicants has been in substantial compliance with the standards as set by applicable state and federal law for the previous twelve-month period before application for licensure.

(6)(A) Except as provided in subdivision (e)(6)(B) of this section, the buyer shall not be issued a license until the buyer provides the department with proof of payment by the buyer to the seller of a sum equal to the annual fee under subsection (i) of this section.

(B) The department shall process a renewal application before issuing a license to a buyer if:

(i) The buyer provides the department with proof of payment by the buyer to the seller of a sum equal to the annual fee under subsection (i) of this section;

(ii) The sale occurs between March 1 and July 1 of any year;

(iii) The seller applied for or received a renewal of the license; and

(iv) The seller paid the annual fee under subsection (i) of this section to the department.

(f)(1) Before issuing a license, or approving the operation of any long-term care facility which was not licensed at the time of application or any additional bed capacity of a licensed facility, the department shall consider and may deny a license based upon the criteria established in subdivision (e)(5) of this section.

(2) This subsection is not intended to circumvent or alter the requirements set forth in § 20-8-101 et seq.

(g) Except for facilities operated by the State of Arkansas, each long-term care facility shall pay an annual licensure fee in the following amount:

(1) Residential care facilities shall pay an annual fee determined by multiplying five dollars (\$5.00) by the total number of licensed resident beds;

(2) Adult day care and adult day healthcare facilities shall pay an annual fee determined by multiplying five dollars (\$5.00) by the maximum number of persons the facility can serve; and

(3) All other long-term care facilities shall pay an annual fee determined by multiplying ten dollars (\$10.00) by the total licensed resident beds or maximum licensed client population.

(h) Annual licensure fees shall be tendered with each application for a new long-term care facility license and with each long-term care facility license renewal application.

(i)(1) Annual licensure fees are payable in one (1) sum.

(2) Fees for new licensure applications may be prorated by dividing the total fee by three hundred sixty-five (365) and multiplying the result by the number of days from the date the application is approved through June 30, inclusive.

(3) Applications for licensure renewal shall be delivered, or if mailed shall be postmarked, on or before March 1.

(j) Any fee not paid when due shall be delinquent and shall be subject to assessment of a ten percent (10%) penalty.

(k) No license or licensure renewal shall be issued unless the annual licensure fee has been paid in full.

(l) Licenses shall be issued only for the premises and persons named in the application and shall not be transferable.

(m) All funds derived from fees collected pursuant to §§ 20-10-213 — 20-10-228 shall be deposited into the State Treasury and credited to the Division of Economic and Medical Services Administrative Fund to be used for the maintenance and operation of the long-term care facility licensure program.

(n) The Department of Human Services shall not require a license for an adult day care program that is excepted from the definition of long-term care facility under § 20-10-101.

History. Acts 1961, No. 414, § 19; 1965, No. 434, § 1; 1971, No. 258, § 2; A.S.A. 1947, § 82-345; Acts 1989, No. 485, § 1; 1989, No. 665, § 1; 1993, No. 1238, §§ 1-3; 1999, No. 1181, § 10; 2005, No. 656, § 1; 2009, No. 216, §§ 1, 2; 2009, No. 357, § 2; 2013, No. 1132, § 5.

A.C.R.C. Notes. Health Services Permit Agency, § 20-8-101 et seq.

Amendments. The 2013 amendment added subdivision designations in (i); and deleted “quotient, that is, the” following “multiplying” in (i)(2).

CASE NOTES

In General.

Judgment in favor of executrix of deceased nursing home facility resident's estate on claims brought under § 20-10-1209(a)(1) against a management company and nursing home facility was reversed as to the management company

because no license was issued to the management company; thus, under the plain language of this section, the management company was not a licensee subject to suit for violation of the resident's rights. *Health Facilities Mgmt. Corp. v. Hughes*, 365 Ark. 237, 227 S.W.3d 910 (2006).

20-10-225. Alterations, additions, and new construction of facilities.

(a) The Department of Human Services shall prescribe by regulation that any licensee or applicant desiring to make specified types of

alterations or additions to its facilities or to construct new facilities shall, before commencing such alterations, additions, or new construction, submit plans and specifications for them to the department for preliminary inspection and approval or recommendations with respect to compliance with the regulations and standards.

(b) From time to time, the Director of the Department of Human Services or his or her agent shall inspect each construction project approved by the United States Surgeon General. If the inspection so warrants, the director or his or her agent shall certify to the United States Surgeon General that work has been performed upon the project, or purchases have been made, in accordance with the approved plans and specifications, and that payment of an installment of federal funds is due the applicant.

History. Acts 1961, No. 414, § 21; A.S.A. 1947, § 82-347; Acts 1987, No. 143, § 3, is also codified as § 20-9-217.

Publisher's Notes. Acts 1987, No. 143, § 3, is also codified as § 20-9-217.

CASE NOTES

Nursing Home Applicants.

The Department of Human Services regulates any applicant or licensee that desires to make alterations or additions to existing facilities or the construction of new facilities, and an applicant must submit plans for such altered, expanded or new facility before construction is com-

menced, without exception for nursing home applicants submitting requests under Acts 1987, No. 593, which created exemptions from certain certificate of need and permit requirements. Ark. Dep't of Human Servs. v. Hillsboro Manor Nursing Home, Inc., 304 Ark. 476, 803 S.W.2d 891 (1991).

20-10-226. Inspections of facilities.

The Department of Human Services shall make such inspections as it may prescribe by regulation.

History. Acts 1961, No. 414, § 21; A.S.A. 1947, § 82-347.

20-10-227. Annual report.

The Department of Human Services shall make an annual report of its activities and operations under §§ 20-10-213 — 20-10-228 to the Governor and shall make such information available to the General Assembly as may be requested.

History. Acts 1961, No. 414, § 24; A.S.A. 1947, § 82-350.

20-10-228. Information received by Department of Human Services confidential.

(a) Except in a proceeding involving the question of licensing or revocation of a license or as permitted in § 20-10-210(b), information received by the Department of Human Services, through inspection or

otherwise, authorized under §§ 20-10-213 — 20-10-228, shall not be disclosed publicly in such a manner as to identify long-term care facility residents, their families, or persons filing complaints.

(b)(1) However, in the case of a specific written request by the deputy director of the appropriate division as determined by the Director of the Department of Human Services for information concerning a certain long-term care facility, information obtained during recent inspections of the facility may be supplied in writing to the deputy director.

(2) This exception applies only to facilities providing care for recipients of public welfare and is not to be construed as permitting the exchange of such information on all homes in the state but is specifically limited to those for which the appropriate division as determined by the Director of the Department of Human Services has specific complaints.

(3) These complaints shall be forwarded to the department along with the request for information from the deputy director.

(4) Information received by the deputy director in the manner prescribed in this subsection shall not be disclosed.

History. Acts 1961, No. 414, § 23; Acts 1999, No. 1539, § 2; 2001, No. 1774, 1965, No. 434, § 2; A.S.A. 1947, § 82-349; § 2.

RESEARCH REFERENCES

Ark. L. Rev. Watkins, Access to Public Records Under the Arkansas Freedom of Information Act, 37 Ark. L. Rev. 741.

U. Ark. Little Rock L. Rev. Survey of

Legislation, 2001 Arkansas General Assembly, Public Health and Welfare, 24 U. Ark. Little Rock L. Rev. 557.

20-10-229. Annual disclosure statement — Requirement.

(a) Any person, corporation, partnership, or facility seeking a license or renewal to provide long-term care in this state shall furnish a current annual disclosure statement to all residents upon request or to all prospective residents upon request.

(b) The statement shall be filed along with the annual application for licensure by March 1 of each year.

(c) The statement shall be on forms and in a format as prescribed by the Department of Human Services and shall include the following information:

(1) The name and business address of the facility and a statement as to whether the facility is a partnership, corporation, or other type of legal entity;

(2) The names and business addresses of the officers, directors, trustees, managing or general partners, or any persons having a five percent (5%) or greater equity or beneficial interest in or of the facility and a description of each person's interest in or occupation with the facility;

(3) A statement as to whether the facility, or any of its officers, directors, trustees, partners, or administrators, before the date of application:

(A) Has ever been convicted of Medicare or Medicaid fraud or felony;

(B) Has ever been convicted of fraud, embezzlement, fraudulent conversion, or misappropriation of property; or

(C) Has had final administrative judgment on any Class A or Class B violations within the last two (2) years;

(4) The location and description of the physical property or property of the facility;

(5) The disclosure statement shall clearly state which services are included in basic care contracts for long-term care and which services are available at or by the facility at extra charge; and

(6) A copy of the contract used by the facility.

History. Acts 1989, No. 664, § 1; 2009, No. 216, § 3.

20-10-230. Annual disclosure statement — Filing.

Each facility shall file the completed annual disclosure statement along with its annual license application by March 1 of each year and file a copy of the disclosure statement with the Department of Human Services county office in the county in which the facility is located.

History. Acts 1989, No. 664, § 1; 2009, No. 216, § 4.

20-10-231. Annual disclosure statement — Violations.

The failure to provide to any resident a copy of the disclosure statement upon request or to a prospective resident upon request or the failure of any facility to disclose the required information in a timely manner or the failure to file the disclosure statement as required shall be grounds for a Class C violation, pursuant to § 20-10-205.

History. Acts 1989, No. 664, § 1.

20-10-232. Regulations, client rights, and sanctions.

(a) The Office of Long-Term Care shall promulgate and maintain pursuant to the Arkansas Administrative Procedure Act, § 25-15-201 et seq., separate regulations, client rights, and sanctions for intermediate care facilities for individuals with developmental disabilities operations and for other long-term care facilities regulated by the office.

(b) Regulations which cover all facilities regulated by the office shall be included in each separate set of regulations. Changes and updates to each set of regulations shall specify which type of regulations are being updated or changed.

History. Acts 1991, No. 922, § 19; 1991, No. 1129, § 25.

20-10-233. [Repealed.]

Publisher's Notes. This section, concerning the oversight subcommittees for community-based care facilities, was repealed by identical Acts 2016 (3rd Ex.

Sess.), Nos. 2 and 3, § 39. The section was derived from Acts 1991, No. 922, § 20; 1991, No. 1129, § 26.

20-10-234. Relicensing bed capacity.

A long-term care facility that reduced its licensed bed capacity within the past forty (40) months from April 2, 1997, may relicense those beds by paying the license fees applicable for that period of time.

History. Acts 1997, No. 1025, § 2.

SUBCHAPTER 3 — LONG-TERM CARE FACILITY ADVISORY BOARD

SECTION.

20-10-301, 20-10-302. [Repealed.]

20-10-303. [Repealed.]

20-10-301, 20-10-302. [Repealed.]

Publisher's Notes. These sections, concerning the creation and operation of the Long-Term Care Facility Advisory Board, were repealed by Acts 2017, No. 540, § 39. The sections were derived from the following sources:

20-10-301. Acts 1969, No. 58, §§ 8-10; 1979, No. 28, §§ 7, 8; 1985, No. 884, § 1;

1985, No. 968, § 1; A.S.A. 1947, §§ 6-623 — 6-626, 82-2208 — 82-2210; Acts 1988 (4th Ex. Sess.), No. 18, § 1; 1997, No. 250, § 181; 2015, No. 1100, § 47.

20-10-302. Acts 1969, No. 58, § 11; 1979, No. 28, § 9; 1985, No. 884, § 2; 1985, No. 968, § 2; A.S.A. 1947, § 82-2211.

20-10-303. [Repealed.]

Publisher's Notes. This section, concerning the authority of the Long-Term Care Facility Advisory Board to hear appeals, was repealed by Acts 2005, No. 898, § 4. The section was derived from Acts

1969, No. 58, § 11; 1979, No. 28, § 9; 1985, No. 884, § 2; 1985, No. 968, § 2; A.S.A. 1947, § 82-2211; Acts 1987, No. 981, § 1.

SUBCHAPTER 4 — LICENSING OF LONG-TERM CARE FACILITY ADMINISTRATORS

SECTION.

20-10-401. Penalty.

20-10-402. License required.

20-10-403. Qualifications.

20-10-404. Application and fees.

20-10-405. Renewal.

SECTION.

20-10-406. Reciprocity.

20-10-407. Denial, revocation, or suspension.

20-10-408. Disposition of funds.

Effective Dates. Acts 1969, No. 58, § 17: Jan. 1, 1970.

Acts 1971, No. 721, § 4: Apr. 28, 1971. Emergency clause provided: "It is hereby found and determined by the General Assembly that the present laws of this State relating to the licensing of nursing home administrators are in need of immediate revision in order to clarify such laws and to assure that only competent and qualified persons are licensed as nursing home

administrators in this State; that this Act is designed to accomplish these purposes and to thereby assure the citizens of this State that nursing home administrators in this State are competent and qualified for the position they hold. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

RESEARCH REFERENCES

ALR. Licensing and regulation of nursing and rest homes. 53 A.L.R.4th 689.

Am. Jur. 40A Am. Jur. 2d, Hospitals, §§ 5, 6.

20-10-401. Penalty.

(a) Any person, partnership, association, or corporation establishing, conducting, managing, or operating any long-term care facility without first obtaining a license as provided by law shall be guilty of a Class A misdemeanor and upon conviction shall be liable to a fine imposed pursuant to a Class A misdemeanor.

(b) Each day that a long-term care facility shall operate after a first conviction shall be considered a Class D felony and upon conviction shall be liable to a fine imposed pursuant to a Class D felony.

History. Acts 1985, No. 884, § 4; 1985, No. 968, § 4; A.S.A. 1947, § 82-2234.

A.C.R.C. Notes. Acts 1987, No. 714, § 1, amended Acts 1985, No. 968, § 4, which is codified in this section. However Acts 1987, No. 714, § 2, provided: "Sec-

tion 20 of Act 414 of 1961 and Section 4 of Act 884 of 1985 are hereby repealed and this act shall terminate June 30, 1989."

The effect of this provision on this section, in which Acts 1985, No. 884, § 4, is also codified, is unclear.

20-10-402. License required.

(a) It shall be unlawful for any person to act or serve in the capacity of nursing home administrator in this state unless the person has been licensed to do so as authorized in this subchapter.

(b) A person who serves as an administrator of a long-term care facility conducted exclusively for persons who rely upon treatment by spiritual means through prayer in accordance with the creed or tenets of a church or religious denomination shall be exempt from subsection (a) of this section and § 20-10-101(1)-(6), § 20-10-203(b), § 20-10-212, §§ 20-10-301 — 20-10-303 [repealed], § 20-10-403, § 20-10-405(b), § 20-10-406, and § 20-10-407.

History. Acts 1969, No. 58, §§ 2, 15; 1971, No. 721, § 1; A.S.A. 1947, §§ 82-2202, 82-2215.

Cross References. Operating institution without a license, §§ 20-9-202, 20-9-203.

20-10-403. Qualifications.

(a) The Office of Long-Term Care is vested with the authority and duty to prescribe minimum qualifications for long-term care facility administrators and license persons as long-term care facility administrators who make application for licensure and meet the minimum qualifications as prescribed in this section and by regulation of the office.

(b) No license shall be issued to a person as a long-term care facility administrator unless:

(1) He or she is at least twenty-one (21) years of age, of good moral character, and of sound physical and mental health;

(2) He or she has:

(A) Satisfactorily completed a course of instruction and training prescribed by the office. The course shall be so designed as to content and administered so as to present sufficient knowledge of the needs properly to be served by long-term care facilities, laws governing the operation of long-term care facilities and the protection of the interests of patients therein, and the elements of good long-term care facility administration;

(B) Presented evidence satisfactory to the office of sufficient education, training, or experience in the foregoing field to administer, supervise, and manage a long-term care facility; or

(C) Participated for one (1) year in an administrator-in-training program approved by the office; and

(3) He or she has passed an examination administered by the office and designed to test for competence in the subject matter referred to in subdivision (b)(2) of this section.

History. Acts 1969, No. 58, § 2; 1975, No. 119, § 2; A.S.A. 1947, § 82-2202.

20-10-404. Application and fees.

(a) Any person desiring to be licensed as a nursing home administrator shall make application to the Office of Long-Term Care on forms prescribed by the office and shall furnish such information with the application as shall be required by the office.

(b) An applicant shall complete the licensure process within one and one-half (1½) years from the date of application approval for licensure.

(c) Each application shall be accompanied by a licensure fee of one hundred dollars (\$100), one half (½) of which shall be refunded to the applicant if he or she is refused licensure by the office.

(d) This section and §§ 20-10-405 and 20-10-408 only apply to nursing home administrators and are not intended to require administrators in other kinds of long-term care facilities unless provided by regulation.

History. Acts 1985, No. 884, § 5; 1985, No. 968, § 5; A.S.A. 1947, § 82-2235; Acts 1987, No. 320, § 1.

A.C.R.C. Notes. A purported amend-

ment to § 20-10-401 contains provisions on licensing that may affect this section. See notes to § 20-10-401.

20-10-405. Renewal.

(a) Every active nursing home administrator's license shall be renewed on or before July 1 of each year by paying a fee of one hundred dollars (\$100) to the Office of Long-Term Care and by furnishing written documentation that the licensee has attended and accumulated a specific number of continuing education clock hours as established by the office.

(b) The fee for those nursing home administrators not actively employed by a nursing home facility as an administrator shall be fifty dollars (\$50.00), payable on or before July 1 of each year.

(c) If the annual licensure fee in full along with the renewal application and satisfactory documentation of compliance with continuing education requirements is not postmarked or received by the office on or before July 1, the licensee shall be ineligible to perform the duties of nursing home administrator, and the license shall be deemed suspended effective July 2.

(d) No request for renewal postmarked or received by the office after July 1 shall be considered unless, in addition to other requirements imposed by law or regulation, the licensee tenders a late charge in the amount of fifty dollars (\$50.00).

(e) Any license not renewed on or before September 1 shall expire effective September 2.

History. Acts 1969, No. 58, § 6; 1975, 2235; Acts 1987, No. 320, §§ 1, 2; 1995, No. 119, § 5; 1985, No. 884, § 5; 1985, No. No. 469, § 1.
968, § 5; A.S.A. 1947, §§ 82-2206, 82-

20-10-406. Reciprocity.

(a) The Office of Long-Term Care may by regulation establish terms and conditions for reciprocity licensure of individuals currently licensed in good standing as long-term care facility administrators in other states.

(b) At their option, applicants qualifying for reciprocity licensure may be granted a nonrenewable temporary license not to exceed one hundred twenty (120) days upon condition of payment of a fifty-dollar temporary license fee and upon meeting the terms and conditions established by the office for the temporary license.

History. Acts 1969, No. 58, § 4; 1975, No. 119, § 4; A.S.A. 1947, § 82-2204; Acts 1995, No. 469, § 2.

20-10-407. Denial, revocation, or suspension.

(a) The Office of Long-Term Care may refuse to issue or renew a long-term care facility administrator's license or may revoke or suspend the license of a long-term care facility administrator if the office finds that the applicant or licensee does not qualify for licensure or has violated § 20-10-101(1)-(6), § 20-10-203(b), § 20-10-212, §§ 20-10-301 — 20-10-303 [repealed], § 20-10-402, § 20-10-403, § 20-10-405(b), § 20-10-406, and this section or regulations of the office relating to the proper administration and management of a long-term care facility.

(b) Any denial of the issuance or renewal of a long-term care facility license or a long-term care facility administrator's license or the revocation or suspension of the license shall be after notice and hearing before an impartial hearing officer as provided in § 20-10-208 and shall be subject to judicial review as provided in § 20-10-212.

History. Acts 1969, No. 58, § 7; A.S.A. 1947, § 82-2207; Acts 2005, No. 898, § 5.

20-10-408. Disposition of funds.

(a) All funds derived from fees collected pursuant to this subchapter are special revenues and shall be deposited into the State Treasury, there to be credited to the Nursing Home Personnel Training Fund to be utilized by the Office of Long-Term Care for development and implementation of training programs as may be prescribed by the office.

(b) Subject to rules and regulations as may be implemented by the Chief Fiscal Officer of the State, the disbursing officer for the Department of Human Services may transfer all unexpended funds relative to the licensure of nursing home administrators that pertain to fees collected, as certified by the Chief Fiscal Officer of the State, to be carried forward and made available for expenditures for the same purpose for any following fiscal year.

History. Acts 1987, No. 320, § 1.

SUBCHAPTER 5 — LONG-TERM CARE NETWORK

SECTION.

- 20-10-501. Definitions.
- 20-10-502. Coordination of state and non-state agencies.
- 20-10-503. Interagency agreements.
- 20-10-504. Public information campaign.
- 20-10-505. Demonstration projects for assessment agencies.

SECTION.

- 20-10-506. Reports.
- 20-10-507. Training program for home health aide providers.
- 20-10-508. Interagency transfers of funds.

Preambles. Acts 1981, No. 380 contained a preamble which read: "Whereas, the State of Arkansas holds the long term care needs of its citizens as a primary

concern, and recognizes the development of a coordinated and accessible network of long term care and related community-based services as essential in assuring

referral to appropriate services and/or in preventing premature institutionalization; and

"Whereas, several different agencies and departments within State government currently administer funds related to long term care (primarily the Arkansas Department of Health, the Division of Social Services and the Office on Aging and Adult Services);

"Now, therefore"

Effective Dates. Acts 1981, No. 380, § 11: Mar. 9, 1981. Emergency clause provided: "It is hereby found and determined by the General Assembly that the development of a coordinated network of long term care and community-based services is essential to the health and welfare of the people of this State, and that immediate steps toward implementation of the provisions of this Act are necessary to establish this coordinated network without undue delay. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public health and welfare shall be in full force and effect from and after its passage and approval."

Acts 1997, No. 179, § 38: Feb. 17, 1997. Emergency clause provided: "It is hereby

found and determined by the General Assembly that Act 10 of the First Extraordinary Session of 1995 abolished the Joint Interim Committee on Public Health, Welfare, and Labor and in its place established the House Interim Committee and Senate Interim Committee on Public Health, Welfare, and Labor; that various sections of the Arkansas Code refer to the Joint Interim Committee on Public Health, Welfare, and Labor and should be corrected to refer to the House and Senate Interim Committees on Public Health, Welfare, and Labor; that this act so provides; and that this act should go into effect immediately in order to make the laws compatible as soon as possible. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

20-10-501. Definitions.

As used in this subchapter:

(1) "Committees" means the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor or appropriate subcommittees thereof to whom the state agencies in the long-term care network will report the progress of this effort;

(2) "Long-term care and related community-based services" means preventive, diagnostic, therapeutic, rehabilitative, and maintenance services available in the home and a variety of protected environments, including institutions, provided to persons, regardless of age, whose capabilities have been impaired by physical, mental, or emotional disability; and

(3) "State agencies" means the Department of Human Services and any other state agency which administers funds for long-term care and related community-based services.

History. Acts 1981, No. 380, § 1; A.S.A. 1947, § 82-2226; Acts 1997, No. 179, § 24.

20-10-502. Coordination of state and nonstate agencies.

(a) The state agencies which administer funds for long-term care shall work together to achieve a coordinated and accessible network of long-term care and related community-based services, utilizing an orderly and effective interagency referral system.

(b) The state agencies shall develop procedures and guidelines to assure that coordination between state agencies in the long-term care network will take place.

(c) Nonstate agencies shall be encouraged to participate in the long-term care network.

(d) Any nonstate agency which receives state funds related to long-term care services shall be required to abide by the policies and procedures of the long-term care network.

History. Acts 1981, No. 380, § 2; A.S.A. 1947, § 82-2227.

20-10-503. Interagency agreements.

The state agencies shall work out formalized agreements among themselves that will set forth all the elements of this plan.

History. Acts 1981, No. 380, § 3; A.S.A. 1947, § 82-2228.

20-10-504. Public information campaign.

The state agencies shall carry out a public information campaign to inform the citizens of Arkansas about this network of services.

History. Acts 1981, No. 380, § 4; A.S.A. 1947, § 82-2229.

20-10-505. Demonstration projects for assessment agencies.

(a) State agencies shall establish a demonstration project in a limited number of counties in order to develop a comprehensive long-term care assessment system.

(b) This project shall develop the role of assessment agencies for the long-term care network.

(c) These assessment agencies shall not be engaged in the provision of services but shall perform an assessment function to measure the client's total needs in order to refer the client to the appropriate level of care available.

History. Acts 1981, No. 380, § 5; A.S.A. 1947, § 82-2230.

20-10-506. Reports.

(a) The state agencies shall collect and report management and caseload information to the appropriate legislative committees on a quarterly basis.

(b) Each agency shall identify to the committees all agency funds and personnel involved in the delivery of long-term care and related community-based services.

History. Acts 1981, No. 380, § 6; A.S.A. 1947, § 82-2231; Acts 1997, No. 179, § 25.

20-10-507. Training program for home health aide providers.

The state agencies shall develop a plan for training home health aide providers.

History. Acts 1981, No. 380, § 7; A.S.A. 1947, § 82-2232.

20-10-508. Interagency transfers of funds.

(a) The Department of Health, the Department of Human Services, and any other state agency which administers funds and appropriations for long-term care and related community-based services may transfer funds and appropriations among themselves in such amounts as they deem necessary to carry out the intent of this subchapter.

(b) The transfers are to be made upon the request of the state agency, but only after having sought and received the advice of the committees, by the Chief Fiscal Officer of the State.

History. Acts 1981, No. 380, § 8; A.S.A. 1947, § 82-2233; Acts 1997, No. 179, § 26.

SUBCHAPTER 6 — LONG-TERM CARE OMBUDSMAN ACT

SECTION.

20-10-601. Title.

20-10-602. Ombudsman program.

SECTION.

20-10-603. Access to patients.

20-10-601. Title.

This subchapter shall be known and may be cited as the “Long-Term Care Ombudsman Act”.

History. Acts 1987, No. 252, § 1.

20-10-602. Ombudsman program.

The Division of Aging, Adult, and Behavioral Health Services of the Department of Human Services shall establish and administer an ombudsman program in accordance with the Older Americans Act, 42 U.S.C. § 3001 et seq., as amended, and all applicable federal and state

laws, including the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

History. Acts 1987, No. 252, § 2; 2017, No. 913, § 57.

Amendments. The 2017 amendment

substituted “Division of Aging, Adult, and Behavioral Health Services” for “Division of Aging and Adult Services”.

20-10-603. Access to patients.

No ombudsman shall be denied access to any patient or resident in a long-term care facility during any period of operation of the facility.

History. Acts 1987, No. 252, § 3.

SUBCHAPTER 7 — LONG-TERM CARE AIDE TRAINING ACT

SECTION.

20-10-701. Title.

20-10-702. Definition.

20-10-703. Exemptions.

SECTION.

20-10-704. Training program.

20-10-705. Regulations.

20-10-706. [Repealed.]

Effective Dates. Acts 1987, No. 689, § 8; Apr. 7, 1987. Emergency clause provided: “It is hereby found and determined by the General Assembly that the adequacy of personal care for Arkansas residents in long term care facilities could be assured through a formalized training program; that the training program should be implemented as soon as possible to preserve the public peace, health, and safety. Therefore, an emergency is declared to exist and this Act being necessary for the immediate preservation of the public peace, health, and safety shall be in full force and effect from and after its passage and approval.”

Acts 2005, No. 2191, § 11; Apr. 13, 2005. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that various

long-term care facilities are operating in this state without having obtained a license; that there is no state oversight or protection for the vulnerable residents in these facilities; and that there is no way of ensuring that the facilities properly treat and protect these residents under state long-term care laws. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

20-10-701. Title.

This subchapter shall be known and may be cited as the “Long-Term Care Aide Training Act”.

History. Acts 1987, No. 689, § 1.

20-10-702. Definition.

As used in this subchapter, “long-term care facility” means a nursing home, residential care facility, assisted living facility, an adult day-care facility, or any other facility which provides long-term medical or personal care.

History. Acts 1987, No. 689, § 5; 2005, No. 2191, § 6.

20-10-703. Exemptions.

Students who have satisfactorily completed a nursing assistant or aide training program in either a public or private proprietary school licensed by the State of Arkansas are excluded from this subchapter since they will already have attained the skills needed to serve as aides in long-term care facilities.

History. Acts 1987, No. 689, § 4.

20-10-704. Training program.

The Office of Long-Term Care shall establish a training program to be completed by all aides in long-term care facilities who provide personal care to residents.

History. Acts 1987, No. 689, § 2.

20-10-705. Regulations.

(a) The Office of Long-Term Care shall promulgate regulations necessary to implement an aide training program for all long-term care facilities in this state, to prescribe in-service training programs, and to enforce compliance with those programs.

(b)(1) The regulations shall require training programs to:

(A) Provide no fewer than ninety (90) clock hours of training; and

(B) Include in those ninety (90) clock hours no fewer than fifteen (15) clock hours of training specific to Alzheimer’s disease and related dementia.

(2) The training programs required under this subsection shall take effect only if funds are available.

(3) The training program established under this section shall be known as the “Barbara Broyles Training Program”.

History. Acts 1987, No. 689, § 3; 2005, No. 1184, § 1.

20-10-706. [Repealed.]

Publisher’s Notes. This section, concerning the requirement of personal care and home-health aide services to complete

a training program, and registration, certification and exemptions, was repealed by Acts 1992 (1st Ex. Sess.), No. 1, § 6.

The section was derived from Acts 1991, No. 922, § 17.

SUBCHAPTER 8 — HOME HEALTHCARE SERVICES

SECTION.

- 20-10-801. Definitions.
- 20-10-802. Exceptions from licensing requirements.
- 20-10-803. Penalties.
- 20-10-804, 20-10-805. [Repealed.]
- 20-10-806. Administration — Rules and regulations.
- 20-10-807. License required.
- 20-10-808. Application for license — Temporary license.

SECTION.

- 20-10-809. Issuance of licenses.
- 20-10-810. Denial, suspension, or revocation of license.
- 20-10-811. Information confidential.
- 20-10-812. Fees.
- 20-10-813. Transfer of licenses and permits upon dissolution.

Effective Dates. Acts 1995, No. 1321, § 5: Apr. 14, 1995. Emergency clause provided: "It is hereby found and determined by the General Assembly that home health care services should be dealt with by the private sector obtaining licenses or permits of approval from any agency of the state; that this act so provides; and this act should go into effect as soon as possible in order to maximize home health care services throughout this state. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1999, No. 1508, § 19: Apr. 15, 1999. Emergency clause provided: "It is hereby found and determined by the Eighty-second General Assembly that this

act makes various technical corrections in the Arkansas Code; that this act further clarifies the law to provide that the Arkansas Code Revision Commission may correct errors resulting from enactments of prior sessions; and that this act should go into effect immediately in order to be applicable during the codification process of the enactments of this regular session. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

RESEARCH REFERENCES

Am. Jur. 70C Am. Jur. 2d, Soc. Sec., § 2050 et seq.

20-10-801. Definitions.

As used in this subchapter:

- (1) "Agency" means any person, partnership, association, corporation, or other organization, whether public or private, proprietary or nonprofit;
- (2) "Class A license" means that the applicant is at the time of filing an application a Medicare-certified home health agency. If the applicant

is not at the time of filing its application a certified home health agency, it shall be in the process of receiving its certification from the Center for Medicare & Medicaid Services;

(3) "Class B license" means that the application shall show proof of the services provided and the geographical territory in which those services have been provided as of July 20, 1987, and that the applicant shall have requested a survey for the purpose of confirming the services provided and territory covered;

(4) "Division" means the Division of Health Facilities Services;

(5) "Home healthcare services" means the providing or coordinating of acute, restorative, rehabilitative, maintenance, preventive, or health promotion services through professional nursing or by other therapeutic services such as physical therapy, occupational therapy, speech therapy, home health aide, or personal services in a client's residence;

(6) "Home healthcare services agency" means an agency licensed to provide home healthcare services;

(7) "Place of business" means any office of a home health agency including subunits;

(8) "Residence" means a place where a person resides, including a home, nursing home, or convalescent home for the disabled or aged; and

(9) "Subunit" means an organization of an agency that provides home healthcare services and which serves patients in a geographic area different from that of the agency.

History. Acts 1987, No. 956, § 1.

20-10-802. Exceptions from licensing requirements.

The following persons are not required to be licensed under § 20-10-807:

(1) A physician, dentist, registered nurse, or physical therapist who is currently licensed under the laws of this state who provides home health services only to a patient as a part of his or her private office practice when the services are incidental to the office practice;

(2) The following healthcare professionals providing home healthcare services as a sole practitioner:

(A) A registered nurse;

(B) A licensed vocational nurse;

(C) A physical therapist;

(D) An occupational therapist;

(E) A speech therapist;

(F) A medical social worker; or

(G) Any other healthcare professional as determined by the Department of Health;

(3) A nonprofit registry operated by a national or state professional association or society of licensed healthcare practitioners, or a subdivision thereof, that operates solely as a clearinghouse to put consumers in contact with licensed healthcare practitioners who will give care in a

patient's residence and that neither maintains the official patient records nor directs patient services;

(4) An individual whose permanent residence is in the patient's residence;

(5) An employee of a person holding a license under this subchapter who provides home healthcare services only as an employee of the licensed person and who receives no benefit for providing home healthcare services other than wages from the employer;

(6) A home, nursing home, convalescent home, or other institution for the disabled or aged that provides health services only to residents of the home or institution;

(7) A person who provides one (1) health service through a contract with a person licensed;

(8) A durable medical equipment supply company;

(9) A pharmacy or wholesale medical supply company that furnishes those services that relate to drugs and supplies to persons in their homes;

(10) A hospital or other licensed healthcare facility serving only inpatient residents;

(11) A visiting nurse service or home aide service constructed by and for the adherents of a religious denomination for the purpose of providing services for those who depend upon spiritual means through prayer alone for healing; and

(12) Persons providing services to one (1) or more developmentally disabled persons, as defined in § 20-48-101, under a license or certificate from the Division of Developmental Disabilities Services of the Department of Human Services.

History. Acts 1987, No. 956, § 2; 2003, No. 1783, § 1.

20-10-803. Penalties.

(a)(1) Any person who violates any provision of this subchapter or regulations lawfully promulgated under this subchapter shall be guilty of a violation.

(2) Upon conviction, that person shall be liable to a fine of not less than twenty-five dollars (\$25.00) nor more than one hundred dollars (\$100) for the first offense and not less than one hundred dollars (\$100) nor more than five hundred dollars (\$500) for each subsequent offense.

(b) Each day that the person performs home healthcare services after a first conviction shall be considered a subsequent offense.

History. Acts 1987, No. 956, § 5; 2005, No. 1994, § 111.

20-10-804, 20-10-805. [Repealed.]

Publisher's Notes. These sections, 2017, No. 540, § 40. The sections were derived from the following sources:
concerning the Home Health Care Service 20-10-804. Acts 1987, No. 956, § 8.
Agency Advisory Council, its operation, 20-10-805. Acts 1987, No. 956, § 8.
powers and duties, were repealed by Acts

20-10-806. Administration — Rules and regulations.

(a) This subchapter shall be administered by the Division of Health Facilities Services.

(b) The State Board of Health shall adopt, promulgate, and enforce such rules, regulations, and standards as may be necessary for the accomplishment of the purposes of this subchapter. The rules, regulations, and standards shall be modified, amended, or rescinded from time to time by the board as may be in the public interest, after first complying with the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

History. Acts 1987, No. 956, § 3.

20-10-807. License required.

It shall be unlawful for any agency to provide home healthcare services unless licensed pursuant to this subchapter.

History. Acts 1987, No. 956, § 4.

20-10-808. Application for license — Temporary license.

(a) An applicant for a license to provide home healthcare services shall:

(1) File a written application on a form prescribed by the Division of Health Facilities Services;

(2) File with the application the name of the owner of the agency or a list of names of persons who own an interest in the agency and a list of any businesses with which the agency subcontracts and in which the owner or owners of the agency hold as much as five percent (5%) of the ownership;

(3) Establish a place of business within the State of Arkansas that maintains home healthcare services records and directs patient services;

(4) Cooperate with any inspections the division may require for a license and comply with regulations and standards promulgated under this subchapter; and

(5) Pay to the division a license fee as prescribed by § 20-10-812.

(b) In addition to the requirements listed in subsection (a) of this section for new and existing agencies providing home healthcare services on July 20, 1987, those agencies shall furnish the following information for a Class A or Class B license:

(1) For a Class A license, if the applicant is at the time of filing an application a Medicare-certified home health agency, the applicant shall provide proof of its compliance with federal conditions of participation. If the applicant is not at the time of filing its application a certified home health agency, it shall be in the process of receiving its certification from the Center for Medicare & Medicaid Services; and

(2) For a Class B license, the applicant shall show proof of the home healthcare services provided and the geographical territory in which those home healthcare services have been provided as of July 20, 1987, and it shall have requested a survey for the purposes of confirming the home healthcare services provided and the territory covered.

(c) The Director of the Division of Health Facilities Services may issue a temporary license to an applicant for a period not to exceed six (6) months.

History. Acts 1987, No. 956, §§ 3, 9.

20-10-809. Issuance of licenses.

(a)(1) The Director of the Division of Health Facilities Services shall issue licenses for the operation of home healthcare services agencies which are found to comply with this subchapter and with the regulations of the State Board of Health.

(2) The director shall also issue licenses for the operation of subunits of a home healthcare services agency.

(b) Licenses shall be issued to the entity and persons listed in the application for licensure and shall not be transferable.

History. Acts 1987, No. 956, § 4.

20-10-810. Denial, suspension, or revocation of license.

The Director of the Division of Health Facilities Services may deny, suspend, or revoke licensure on any of the following grounds:

(1) Violation of this subchapter or the rules and regulations lawfully promulgated under this subchapter; and

(2) Permitting, aiding, or abetting the commission of any unlawful act in connection with the operation of the home healthcare services agency.

History. Acts 1987, No. 956, § 4.

20-10-811. Information confidential.

Information received by the Director of the Division of Health Facilities Services through inspection or otherwise authorized under this subchapter shall not be disclosed publicly in such manner as to identify individuals or a home healthcare services agency except in a proceeding involving the question of licensing or revocation of a license.

History. Acts 1987, No. 956, § 6.

20-10-812. Fees.

(a)(1) The Division of Health Facilities Services may levy and collect a fee for the issuance of an annual license to a home healthcare services agency or a subunit of a home healthcare services agency. The license fee for a home healthcare services agency shall be an annual fee of one thousand dollars (\$1,000), and the fee for a subunit shall be an annual fee of one hundred dollars (\$100).

(2) The fees collected under this subsection shall be deposited into the Health Facility Services Revolving Fund.

(b) Except for those fees set forth in subsection (a) of this section, all fees levied and collected under this subchapter shall be special revenues and shall be deposited into the State Treasury and credited to the Public Health Fund.

(c) Subject to those rules and regulations that may be implemented by the Chief Fiscal Officer of the State, the disbursing officer for the Department of Health may transfer all unexpended funds relative to this subchapter that pertain to fees collected except for those collected under subsection (a) of this section, as certified by the Chief Fiscal Officer of the State, to be carried forward and made available for expenditures for the same purposes for any following fiscal year.

History. Acts 1987, No. 956, § 7; 1997, No. 574, § 2; 1999, No. 1508, § 9.

20-10-813. Transfer of licenses and permits upon dissolution.

Upon the dissolution of any corporation which on April 14, 1995, is licensed to provide home healthcare services, the Department of Health, the Health Services Permit Agency, the Health Services Permit Commission, and any other agency involved may transfer the dissolved corporation's licenses and permits of approval to a stockholder of the dissolved corporation, and that stockholder may continue to perform home healthcare services under the transferred license and permit of approval.

History. Acts 1995, No. 1321, § 1; 2001, No. 1800, § 16.

SUBCHAPTER 9 — ARKANSAS LONG-TERM CARE FACILITY RECEIVERSHIP LAW

SECTION.

20-10-901. Title.
20-10-902. Purpose.
20-10-903. Definitions.
20-10-904. Grounds for appointment.
20-10-905. Petition for receivership.
20-10-906. Hearing on receivership.
20-10-907. Emergency appointment.

SECTION.

20-10-908. Qualifications of receiver.
20-10-909. Duties of receiver.
20-10-910. Compensation of receiver.
20-10-911. Duration of receivership.
20-10-912. Bond of receiver.
20-10-913. Automatic stay.
20-10-914. Accounting for funds.

SECTION.

20-10-915. Alternative procedure.

20-10-916. Long-Term Care Facility Receivership Fund Account.

Publisher's Notes. Acts 1988 (4th Ex. Sess.), No. 3, § 2, and No. 13, § 2, provided that if any part of this subchapter is found to conflict with federal requirements which are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this subchapter is declared to be inoperative solely to the extent of the conflict, and such finding or determination shall not affect the operation of the remainder of this subchapter.

Effective Dates. Acts 1988 (4th Ex. Sess.), No. 3, § 4 and No. 13, § 4: July 15, 1988. Emergency clause provided: "It is hereby found and determined by the General Assembly that during recent months, certain inadequacies in the continuum of health care for the older citizens of this

State have been brought to the attention of the General Assembly; that this Act is necessary to assure each citizen of this State in need of long-term care that a high quality of care at affordable cost will be provided; that the older citizenry of this State deserve the best possible care; that the immediate passage of this Act is essential to the health, welfare and safety of the citizens of the State of Arkansas and to avoid irreparable harm upon the proper administration of an essential government program. Therefore, an emergency is hereby declared to exist and this act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

20-10-901. Title.

This subchapter may be known as the "Arkansas Long-Term Care Facility Receivership Law".

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1.

20-10-902. Purpose.

It is the purpose of this subchapter to develop a mechanism whereby the concept of receivership can be utilized for the protection of residents in long-term care facilities. It is the intent of the General Assembly that receivership shall be a remedy of last resort when all other methods of remedy have failed or when the implementation of other remedies would be futile. It is not the intent of this subchapter to circumvent the Health Services Permit Program of the Health Services Permit Commission. No court or administrative agency shall interpret the contents of this subchapter to allow the transfer of beds or the license of a facility under receivership without approval of the commission as required by § 20-8-101 et seq.

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1; 2001, No. 1800, § 17.

20-10-903. Definitions.

As used in this subchapter:

(1) "Administrator" means a long-term care facility administrator as defined in § 20-10-101;

(2) "Emergency" means a situation, a physical condition, or one (1) or more practices, methods, or operations which threaten the health, security, or welfare of residents;

(3) "Facility" means a long-term care facility which is required to be licensed under § 20-10-224;

(4) "Habitual violation" means a violation of state or federal law which, due to its repetition, presents a reasonable likelihood of serious physical or mental harm to residents;

(5) "Licensee" means any person or any other legal entity that is licensed or required to be licensed to operate a facility;

(6) "Owner" means the holder of the title to the real estate in which the facility is maintained;

(7) "Resident" means any person who lives in and receives services or care in a long-term care facility; and

(8) "Substantial violation" means a violation of state or federal law which presents a reasonable likelihood of serious physical or mental harm to residents.

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1.

20-10-904. Grounds for appointment.

The following circumstances shall be grounds for the appointment of a receiver to operate a long-term care facility:

(1) An emergency exists in a facility which threatens the health, security, or welfare of residents;

(2) A facility is in substantial or habitual violation of the standards of health, safety, or resident care established under state or federal regulations to the detriment of the welfare of the residents;

(3) A facility intends to close but has not arranged at least thirty (30) days before closure for the orderly transfer of its residents;

(4) The facility is insolvent; and

(5) The Department of Human Services has suspended, revoked, or refused to renew the existing license of the facility.

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1.

20-10-905. Petition for receivership.

(a) The Department of Human Services, Attorney General, or prosecuting attorney or duly appointed deputy prosecuting attorney of the district in which the facility is located may file a complaint in the circuit court of the county in which the facility is located requesting the appointment of a receiver.

(b) A complaint for appointment of a receiver pursuant to this subchapter shall have precedence and priority over any civil case pending in the circuit court in which the complaint is filed.

(c) The court shall hold a hearing on the complaint within five (5) days of the filing of the complaint.

(d) The complaint and notice of hearing shall be served on the owner and administrator or licensee of the facility. In cases when the department is not the plaintiff in the action, a copy of the complaint and notice shall be forwarded by mail to the Director of the Department of Human Services by the plaintiff.

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1.

20-10-906. Hearing on receivership.

The court shall appoint a receiver if it finds that any one (1) of the grounds for appointment set forth in § 20-10-904 is satisfied.

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1.

20-10-907. Emergency appointment.

(a) If the complaint filed under § 20-10-905 is filed by the Department of Human Services and alleges that grounds set out in § 20-10-904(1) or § 20-10-904(2) exist within a facility and is accompanied by a verified affidavit setting forth facts which would constitute such a ground, a temporary receiver shall be appointed with or without notice to the owner, licensee, or administrator.

(b) The temporary appointment of a receiver without notice to the owner, licensee, or administrator may be made only if the court is satisfied that the department has made a diligent attempt to provide reasonable notice under the circumstances. The delivery of a copy of the complaint to the facility upon filing shall constitute reasonable notice for issuance of a temporary receivership order by the court.

(c) Upon appointment of a temporary receiver, the department shall proceed immediately to obtain service as provided in § 20-10-905(d).

(d) If the department does not proceed with the complaint, the court shall dissolve the temporary receivership after ten (10) days.

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1; 2007, No. 827, § 152.

20-10-908. Qualifications of receiver.

(a) The circuit court may appoint any licensed nursing home administrator or any qualified person as a receiver who does not have a conflict of interest.

(b) The Department of Human Services shall maintain a list of qualified persons to be furnished to the court. Preference shall be given to persons with experience in delivery of healthcare services and operation of long-term care facilities.

(c) No person may be considered to be qualified to be a receiver who:

- (1) Is the owner, licensee, or administrator of the facility;
- (2) Is affiliated with the facility;
- (3) Has a financial interest in the facility; or
- (4) Has owned or operated a facility that has been ordered into receivership.

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1.

20-10-909. Duties of receiver.

The receiver appointed pursuant to this subchapter:

- (1) Shall operate the facility in such a manner as to assure safety and adequate health care for the residents;
- (2) Shall receive and expend in a reasonable and prudent manner the revenues of the facility;
- (3) May hire, direct, manage, and discharge any employees, including the administrator of the facility;
- (4) Shall be entitled to and shall take possession of all property or assets of residents which are in the possession of the licensee or operator of the facility. The receiver shall preserve all property, assets, and records of residents of which the receiver takes possession;
- (5)(A) May contract for such outside services as may be needed for the operation of the facility.
(B) Any contract for outside services in excess of three thousand dollars (\$3,000) shall be approved by the court;
- (6) Shall pay commercial creditors of the facility determined by the receiver to be valid;
- (7)(A) May do all things necessary and proper to maintain and operate the facility in accordance with sound fiscal policies.
(B) The receiver shall take such action as is reasonably necessary to protect or conserve the assets or property of which the receiver takes possession and may use such assets or property only in the performance of the powers and duties set out in this section;
- (8) Shall conduct the day-to-day business operations of the facility;
- (9)(A) Shall correct or eliminate any deficiency in the structure or furnishings of the facility which endangers the safety or health of residents while they remain in the facility, provided the total cost of correction does not exceed three thousand dollars (\$3,000).
(B) The circuit court may order expenditures for this purpose in excess of three thousand dollars (\$3,000) upon application from the receiver, after notice to the owner and hearing;
- (10) Shall collect incoming payments from all sources and apply them to the costs incurred in the performance of his or her functions as receiver, including the compensation of the receiver;

(11) Shall honor existing leases, mortgages, chattel mortgages, and security interests determined by the receiver to be valid;

(12) Shall remedy violations of federal and state regulations governing the operation of the facility;

(13) May close the facility or negotiate with the owners for the sale of the facility upon approval of the court;

(14) Shall give each resident of the facility and the family representative of each resident notice of the receivership;

(15)(A) May hire consultants or undertake any studies of the facility he or she deems appropriate.

(B) Any expenditure under this subdivision (15) in excess of three thousand dollars (\$3,000) shall be approved by the court.

(C) "Consultants" excludes the owner, licensee, administrator, persons affiliated with the facility, persons with a financial interest in the facility, and persons who have owned or operated a facility that has been ordered into receivership unless approved by the court; and

(16) Shall file reports concerning the receivership and expenditures with the court in such frequency as the court deems appropriate and shall forward a copy of each report to the owner and administrator or licensee of the facility.

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1.

20-10-910. Compensation of receiver.

(a) The circuit court shall set a reasonable compensation to include salary and reasonable expenses for the receiver to be paid as a necessary expense of the facility under the receivership. Reasonable expenses may include charges for a liability insurance policy covering negligence of the receiver and employees of the facility for the duration of the receivership.

(b) If the receiver does not have sufficient funds to pay the salary from the revenues of the facility, the receiver may petition the court for permission to file a claim with the Department of Human Services for payment from the Long-Term Care Facility Receivership Fund Account as established in § 20-10-916.

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1.

20-10-911. Duration of receivership.

(a) The receiver shall be appointed for an initial period of not more than six (6) months.

(b) The initial six-month period may be extended for an additional period of ninety (90) days with approval of the circuit court upon a showing of good cause.

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1.

20-10-912. Bond of receiver.

The circuit court may require a receiver to post a bond, which may include provision for costs and attorney's fees, upon breach of fiduciary duty.

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1.

20-10-913. Automatic stay.

(a) No person or court of this state shall impede the operation of a receivership created under this subchapter.

(b) For a sixty-day period subsequent to the appointment of a receiver, there shall be an automatic stay of any action that would interfere with the functioning of the facility, including, but not limited to, cancellation of insurance policies executed by the licensee, termination of utility services, executions, attachments or setoffs, and repossession of equipment used in the facility.

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1.

20-10-914. Accounting for funds.

Within thirty (30) days after termination, the receiver shall file with the court a complete accounting of all property of which the receiver has taken possession, of all funds collected, and of the expenses of the receivership.

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1.

20-10-915. Alternative procedure.

(a)(1) In lieu of bringing an action under this subchapter, the Department of Human Services, in its sole discretion, may place a designated employee from the department to act as monitor in the facility when any of the grounds for receivership exists in a facility.

(2) The monitor shall observe operation of the facility, assist the facility by advising it on how to comply with the state and federal regulations, and report periodically to the department on the operation of the facility.

(3) A monitor shall remain in a facility not to exceed sixty (60) days.

(b) At the end of the monitoring period, if the department determines that insufficient progress has been made by the facility for elimination of the grounds for appointment of a receivership, the department may proceed for appointment of a receivership upon the grounds which existed at the time of placement of the monitor in the facility.

(c) The department may promulgate any rules and regulations as necessary to implement this section.

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1.

20-10-916. Long-Term Care Facility Receivership Fund Account.

(a) There is established on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a fund account to be known as the "Long-Term Care Facility Receivership Fund Account" of the Department of Human Services Fund. The fund account shall consist of general revenues and such other funds as may be provided by law.

(b) The fund account established in this section shall be administered and disbursed under the direction of the Director of the Department of Human Services for the purpose of paying the expenses of receivers appointed under this subchapter.

(c) No money shall be expended from this fund account for any purpose except when the funds generated by a long-term care facility in this state are found to be insufficient by a court of law to pay the reasonable expenses of a receiver after all other operating expenses of the facility have been paid from the facility's revenue.

(d) Any balance remaining in the fund account at the close of each fiscal year shall be retained in that fund account to be available for the same purposes.

(e) Beginning July 1, 1991, and each July 1 of an odd-numbered year thereafter, the Treasurer of State shall transfer from the General Revenue Fund Account of the State Apportionment Fund to the Long-Term Care Facility Receivership Fund Account an amount sufficient to maintain a fund balance of one hundred thousand dollars (\$100,000).

History. Acts 1988 (4th Ex. Sess.), No. 3, § 1; 1988 (4th Ex. Sess.), No. 13, § 1.

SUBCHAPTER 10 — OMNIBUS LONG-TERM CARE REFORM ACT OF 1988

SECTION.

- 20-10-1001. Title.
- 20-10-1002. Intent.
- 20-10-1003. Residents' rights.
- 20-10-1004. Prohibiting new admissions — Hearings and appeals.
- 20-10-1005. Procedure for transfer or discharge of residents — Violations.
- 20-10-1006. Residents' councils — Staff coordinators — Family councils.

SECTION.

- 20-10-1007. Adverse action against residents prohibited — Violations.
- 20-10-1008. Disposition of civil penalties.
- 20-10-1009. Right to rescind long-term care contracts.
- 20-10-1010. End-of-life treatment of long-term care residents.

A.C.R.C. Notes. This subchapter may be affected by § 20-10-1201 et seq.

Effective Dates. Acts 1988 (4th Ex. Sess.), No. 17, § 6: July 15, 1988. Emergency clause provided: "It is hereby found and determined by the General Assembly that the state lacks procedures to adequately protect the infirmed and frail elderly who reside in long-term care facilities within this state; That this act should go into effect immediately upon passage to shorten the amount of time required for necessary rules and regulations to be pro-

mulgated for implementation of this act and to provide at the earliest possible date some assurance to the residents of long-term care facilities that a high quality of life and the protection of their welfare and health is necessary and important to the entire citizenry of the State of Arkansas. Therefore, an emergency is hereby declared to exist and this act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

20-10-1001. Title.

This subchapter may be known as the "Omnibus Long-Term Care Reform Act of 1988".

History. Acts 1988 (4th Ex. Sess.), No. 17, § 1.

20-10-1002. Intent.

It is the intent of the General Assembly to provide protection for those citizens residing in long-term care facilities to assure the residents the highest quality of life while protecting their health and welfare.

History. Acts 1988 (4th Ex. Sess.), No. 17, § 1.

20-10-1003. Residents' rights.

(a) A long-term care facility shall protect and promote the rights, benefits, or privileges guaranteed by law, the United States Constitution, and the Arkansas Constitution for all residents.

(b) The Office of Long-Term Care shall promulgate through rules and regulations a residents' bill of rights which shall include provisions addressing each of the following as a minimum statement of residents' rights. The office may place restrictions or limitations on any right listed in this subsection when that is necessary to protect the health, welfare, or safety of the resident or other residents:

- (1) The right to exercise all constitutional and legal rights;
- (2) The right to a safe and clean environment;
- (3) The right to dignity and respect;
- (4) The right to nursing and medical care;
- (5) The right to personal cleanliness;
- (6) The right to choose at their own expense a personal physician and pharmacist;
- (7) The right to have knowledge and input into medical treatment, records, and plan of care;
- (8) The right to refuse experimental treatment;

(9) The right to confidentiality of medical records;

(10)(A) The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

(B) Restraints may be imposed only to ensure the physical safety of the resident or of other residents and only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used, except for emergency conditions until such an order could reasonably be obtained;

(11) The right to exercise civil liberties, including the right to vote;

(12) The right to the free exercise of religion, including the right to rely on spiritual means for treatment;

(13) The right to privacy, including the right to refuse being photographed by persons other than those licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.;

(14) The right to personal clothing and belongings;

(15) The right to personal financial information; and

(16) The right to direct whether to receive nutrition or hydration.

(c) The office shall prescribe a procedure to be followed by all long-term care facilities for prompt reporting of violations of residents' rights and resolution of grievances.

(d) The long-term care facility shall furnish a copy of the residents' bill of rights to each resident or resident's representative at the time of admission and to each employee of the facility. A written acknowledgment of receipt shall be included by the facility in the resident's file and personnel file of each employee.

(e)(1) Failure to comply with the provisions of this section or verified violations of residents' rights shall be considered a Class B violation under § 20-10-205 for which civil penalties set forth in § 20-10-206 may be imposed.

(2) Any appeal shall be under the procedure set forth in § 20-10-208.

(f) A second or subsequent offense, for purposes of determining a penalty amount, means a violation of the same right previously violated although it need not have been committed by the same employee of the facility or against the same resident.

(g) The office shall prescribe through rules and regulations a synopsis of the residents' bill of rights which shall be posted at all times in a conspicuous location accessible to residents and the public in the facility.

History. Acts 1988 (4th Ex. Sess.), No. 17, § 1; 1989, No. 33, § 1; 2003, No. 1322, § 1.

A.C.R.C. Notes. Acts 2003, No. 1322, § 6, provided: "Legislative purpose.

"(a)(1) The General Assembly recognizes that residents of long-term care fa-

cilities are among the most vulnerable of the state's citizens.

"(2) Further, the disproportionate number of these residents who are Medicaid eligible, and who have little or no close family involvement in their lives, heightens their vulnerability.

“(b) It is the intent of the General Assembly that, to ensure proper care and treatment of these individuals, particularly at end-of-life, the circumstances and conditions under which the withholding of nutrition, hydration, or both, may occur, be clarified.”

20-10-1004. Prohibiting new admissions — Hearings and appeals.

(a) The Director of the Office of Long-Term Care may prohibit new admissions to a long-term care facility not in compliance due to a Class A violation until the Office of Long-Term Care determines the facility is in substantial compliance.

(b) If the director determines to prohibit admissions to a facility, he or she shall notify the administrator of the facility in writing, by certified mail or other means which gives actual notice, that the facility is prohibited from admitting any new residents due to a Class A violation and that the prohibition shall continue until the office makes a determination that the facility has corrected the deficiency and is in substantial compliance.

(c)(1) The facility may request an immediate hearing by written request to the Director of the Department of Human Services.

(2) The department shall provide a fair and impartial hearing officer within ten (10) days of receipt of the request.

(3) Unless in conflict with this subsection, the procedure for hearings and appeals set forth in § 20-10-208 shall be followed.

History. Acts 1988 (4th Ex. Sess.), No. 17, § 1.

20-10-1005. Procedure for transfer or discharge of residents — Violations.

(a) The Office of Long-Term Care shall prescribe through rule or regulation the procedure for transfer or discharge of residents to be followed by long-term care facilities. The procedure shall include:

(1) Provisions for a written notice to be furnished to the resident, sponsor, and other appropriate parties thirty (30) days before any involuntary transfer or discharge and for regulations setting forth the following circumstances for which the written notice need not be furnished:

(A) The transfer or discharge is necessary to meet the resident's welfare, and the resident's welfare cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility;

(C) The safety of individuals in the facility is endangered;

(D) The health of individuals in the facility would otherwise be endangered;

(E) The resident has failed, after reasonable and appropriate notice, to pay or to have paid under state-administered programs on the resident's behalf an allowable charge imposed by the facility for

an item or service requested by the resident and for which a charge may be imposed consistent with federal and state laws and regulations; or

(F) The facility ceases to operate;

(2)(A) An appeals process for residents objecting to an involuntary transfer or discharge which places the burden of proof for justification of the transfer or discharge on the facility.

(B) The appeals process for objections to transfer or discharge shall include provisions for the resident or sponsor, within seven (7) days upon receipt of the written notice of transfer or discharge, to file a written objection to the transfer.

(C) Unless otherwise agreed to by the parties:

(i) A hearing shall be scheduled within fourteen (14) days following the filing of the objection; and

(ii) A final determination shall be rendered within seven (7) days following the hearing; and

(3) The contents of the written notice, including a statement in clear and concise language of the appeal process to be followed by the resident and the time periods in which:

(A) The resident must request an appeal;

(B) The appeal must be heard; and

(C) The earliest date a transfer would be allowed if the decision is against the resident.

(b) A request for a hearing shall stay a transfer pending a final determination.

(c) If the facility prevails and the final determination is not rendered within seven (7) days of the conclusion of the hearing, the Department of Human Services shall bear the cost of the resident's continued stay in the long-term care facility until such time as the decision is rendered.

(d) The facility shall provide preparation and orientation to residents to ensure a safe and orderly transfer or discharge.

(e) Failure to comply with the transfer or discharge procedures as prescribed by the office shall be considered a Class B violation under § 20-10-205 for which civil penalties set forth in § 20-10-206 may be imposed.

History. Acts 1988 (4th Ex. Sess.), No. 17, § 1; 2001, No. 1763, § 1; 2007, No. 827, § 153.

20-10-1006. Residents' councils — Staff coordinators — Family councils.

(a) The Office of Long-Term Care shall prescribe through rule or regulation the establishment of a residents' council within each long-term care facility. The residents' council's duties shall include, but need not be limited to:

(1) Review of procedures of the facility for implementation of residents' rights;

(2) Making recommendations for changes or additions in the facility's policies and procedures, including programming;

(3) Representing residents in their complaints to the office or any other person or agency; and

(4) Assisting in early identification of problems and orderly resolution of problems.

(b)(1) The facility administrator shall designate a staff coordinator and designate space within the facility for the residents' council.

(2) The staff coordinator shall assist the residents' council in scheduling regular meetings and preparing written reports of meetings for dissemination to all residents of the facility.

(3) The staff coordinator may be excluded from any meeting of the residents' council.

(c) The office shall prescribe rules or regulations which encourage the establishment of family councils for residents' families to meet in the facility with the families of other residents. The office shall require each facility to inform residents' families of their right to establish a family council within the facility.

(d)(1) Failure to comply with the requirement of establishment and operation of a residents' council as prescribed by the office shall be considered a Class C violation under § 20-10-205 for which civil penalties set forth in § 20-10-206 may be imposed.

(2) Any appeal shall be under the procedure set forth in § 20-10-208.

History. Acts 1988 (4th Ex. Sess.), No. 17, § 1.

20-10-1007. Adverse action against residents prohibited — Violations.

(a) No long-term care facility owner, administrator, employee, or other representative shall discriminate, retaliate, or seek reprisal in any manner against a resident or employee of a long-term care facility who has initiated or participated in any proceeding provided in this subchapter.

(b) Any adverse action taken against a resident of a long-term care facility within one hundred twenty (120) days of the filing of a complaint or initiation of any action shall give rise to a rebuttable presumption that the action was taken by the owner, administrator, employee, or other representative in violation of subsection (a) of this section.

(c) Failure to comply with this section by any facility owner, administrator, employee, or other representative shall be considered a Class B violation under § 20-10-205 for which civil penalties set forth in § 20-10-206 may be imposed.

(d) Any appeal shall be under the procedure set forth in § 20-10-208.

History. Acts 1988 (4th Ex. Sess.), No. 17, § 1.

20-10-1008. Disposition of civil penalties.

All moneys received from the imposition of civil penalties levied by the state on long-term care facilities found to be out of compliance with the requirements of this subchapter shall be deposited into the Long-Term Care Trust Fund for uses as prescribed in § 20-10-209.

History. Acts 1988 (4th Ex. Sess.), No. 17, § 1.

20-10-1009. Right to rescind long-term care contracts.

For a fourteen-day period beginning on the date of entry into a long-term care facility, the resident shall have the right to rescind any contractual obligation into which he or she has entered and receive a full refund of any moneys transferred to the facility. If the resident entered the facility and received some benefit therefrom, the charges of the services provided shall be prorated and payment made only for the benefits conferred.

History. Acts 1989, No. 663, § 1.

20-10-1010. End-of-life treatment of long-term care residents.

(a) For residents suffering from a terminal condition as defined in § 20-17-201, facilities may withhold nutrition or hydration, or both, only pursuant to:

- (1) The directive or with the consent of the resident;
- (2) A validly executed declaration as defined in § 20-17-201; or
- (3) The instructions of a person authorized to execute a written request for another under § 20-17-214 if:

(A) The resident did not execute a declaration; and

(B) In the opinion of the attending physician, the resident is no longer able to make healthcare decisions for himself or herself; or

(4) The directions of an attorney-in-fact appointed under a validly executed durable power of attorney for health care as defined in § 20-13-104 [repealed].

(b) For residents who are permanently unconscious as defined in § 20-17-201, facilities may withhold nutrition or hydration, or both, only pursuant to:

(1) A validly executed declaration as defined in § 20-17-201;

(2) The instructions of a person authorized to execute a written request for another pursuant to § 20-17-214 if:

(A) The resident did not execute a declaration; and

(B) In the opinion of the attending physician, the resident is no longer able to make healthcare decisions for himself or herself; or

(3) The directions of an attorney-in-fact appointed under a validly executed durable power of attorney for health care as defined in § 20-13-104 [repealed].

- (c)(1) Notwithstanding subsections (a) and (b) of this section, the wishes of a resident who requests nutrition or hydration, or both, shall be honored.
- (2) Unless the use of artificial means is specifically requested, a patient's request for nutrition or hydration, or both, shall not be honored by use of artificial means if doing so would require the insertion of any apparatus into the patient's body.
- (d) The attending physician or other healthcare provider may not substitute his or her judgment relating to nutrition or hydration and make a decision that is contrary to the known wishes of the resident.

History. Acts 2003, No. 1322, § 7.

A.C.R.C. Notes. Acts 2003, No. 1322, § 6, provided: "Legislative purpose.

"(a)(1) The General Assembly recognizes that residents of long-term care facilities are among the most vulnerable of the state's citizens.

"(2) Further, the disproportionate number of these residents who are Medicaid eligible, and who have little or no close family involvement in their lives, heightens their vulnerability.

"(b) It is the intent of the General Assembly that, to ensure proper care and treatment of these individuals, particularly at end-of-life, the circumstances and conditions under which the withholding of nutrition, hydration, or both, may occur, be clarified."

This section may be superseded by § 20-6-101 et seq.

SUBCHAPTER 11 — NURSING HOME LICENSING

SECTION.
20-10-1101 — 20-10-1105. [Repealed.]

20-10-1101 — 20-10-1105. [Repealed.]

Publisher's Notes. This subchapter, concerning nursing home licensing, was repealed by Acts 1993, No. 1238, § 9. The subchapter was derived from the following sources:

20-10-1101. Acts 1989, No. 986, § 1.
20-10-1102. Acts 1989, No. 986, § 1.
20-10-1103. Acts 1989, No. 986, § 1.
20-10-1104. Acts 1989, No. 986, § 1.
20-10-1105. Acts 1989, No. 986, § 1.

SUBCHAPTER 12 — PROTECTION OF LONG-TERM CARE FACILITY RESIDENTS

- | | |
|---|---|
| SECTION. | SECTION. |
| 20-10-1201. Purpose. | 20-10-1206. Right of entry and inspection. |
| 20-10-1202. Definitions. | 20-10-1207. Availability, distribution, and posting of reports and records. |
| 20-10-1203. Administration and management of long-term care facilities. | 20-10-1208. Patient records — Penalties for alteration. |
| 20-10-1204. Residents' rights. | 20-10-1209. Civil enforcement. |
| 20-10-1205. Property and personal affairs of residents. | |

Effective Dates. Acts 2003, No. 1473, § 74: July 1, 2003. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that this act includes technical corrections to Act 923 of 2003 which establishes the classification and compensation levels of state employees covered by the provi-

sions of the Uniform Classification and Compensation Act; that Act 923 of 2003 will become effective on July 1, 2003; and that to avoid confusion this act must also be effective on July 1, 2003. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2003.”

Acts 2005, No. 2191, § 11: Apr. 13, 2005. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that various long-term care facilities are operating in this state without having obtained a license; that there is no state oversight or

protection for the vulnerable residents in these facilities; and that there is no way of ensuring that the facilities properly treat and protect these residents under state long-term care laws. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

20-10-1201. Purpose.

The purpose of this subchapter is to provide for the development, establishment, and enforcement of basic standards for:

(1) The health, care, and treatment of persons in long-term care facilities; and

(2) The construction, maintenance, and operation of these facilities which will ensure safe, adequate, and appropriate care, treatment, and health of persons in the facilities.

History. Acts 1999, No. 1181, § 1.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Health Law — The Arkansas Resident’s Rights Statute and Civil Enforcement — Cutting Off Its Nose To Spite Its Face: How the Arkansas Resident’s Rights Statute Is Defeating Its Purpose of Improving Quality

of Care to Nursing Home Residents by Crippling the Nursing Homes Themselves. *Health Facilities Management Corp. v. Hughes*, 29 U. Ark. Little Rock L. Rev. 597.

CASE NOTES

ANALYSIS

Class Certification.
Statute of Limitations.

Class Certification.

Class certification against nursing homes met Ark. R. Civ. P. 23 predominance because common issues existed as to (1) a duty to provide proper staffing under an admission agreement and § 20-10-1201 et seq., (2) liability under the Arkansas Deceptive Trade Practices Act, § 4-88-101 et seq., and (3) whether statu-

tory and contractual duties were met. *GG-NSC Arkadelphia, LLC v. Lamb*, 2015 Ark. 253, 465 S.W.3d 826 (2015).

Statute of Limitations.

Based on review of Arkansas law, appellate court held that an Arkansas Long Term Care Resident’s Rights Act, § 20-10-1201 et seq., claim, would be subject to a three-year limitations period under § 16-56-105; for this and other reasons, an insurer had no duty to defend an operator of a nursing home, but it had a duty to defend the nursing home owner on all

claims in the underlying lawsuit, and that its duty to indemnify the owner extended only to any judgment against it for breach of contract. *Medical Liab. Mut. Ins. Co. v. Alan Curtis LLC*, 519 F.3d 466 (8th Cir. 2008).

Cited: *Koch v. Northport Health Servs. of Ark.*, 361 Ark. 192, 205 S.W.3d 754 (2005); *Deaver v. Faucon Props., Inc.*, 367 Ark. 288, 239 S.W.3d 525 (2006).

20-10-1202. Definitions.

As used in this subchapter:

(1) “Administrator” means a person who administers, manages, supervises, or is in general administrative charge of a long-term care facility;

(2) “Bed reservation policy” means the number of consecutive days and the number of days per year that a resident may leave the long-term care facility for overnight therapeutic visits with family or friends or for hospitalization for an acute condition before the licensee may discharge the resident due to his or her absence from the facility;

(3) “Board” means the Long-Term Care Facility Advisory Board created by § 20-10-301 [repealed];

(4) “Custodial service” means care for a person which entails observation of diet and sleeping habits and maintenance of a watchfulness over the general health, safety, and well-being of the person;

(5) “Department” means the Department of Human Services;

(6) “Long-term care facility” means a nursing home, residential care facility, assisted living facility, post-acute head injury retraining and residential care facility, or any other facility which provides long-term medical or personal care but shall not include any facility which is conducted by and for those who rely exclusively upon treatment by prayer alone for healing in accordance with the tenets or practices of any recognized religious denomination;

(7) “OLTC” means the Office of Long-Term Care created by § 20-10-202;

(8) “Ombudsman” means a long-term care ombudsman established pursuant to the Long-Term Care Ombudsman Act, § 20-10-601 et seq.;

(9) “Resident designee” means a person other than the owner, administrator, or employee of the facility designated in writing by a resident, or a resident’s guardian if the resident is adjudicated incompetent, to be the resident’s representative for a specific, limited purpose; and

(10) “Residential care plan” means a written plan developed, maintained, and reviewed not less than quarterly by a registered nurse, with participation from other facility staff and the resident or his or her designee or legal representative, which includes a comprehensive assessment of the needs of an individual resident, a listing of services provided within or outside the facility to meet those needs, and an explanation of service goals.

History. Acts 1999, No. 1181, § 2; 2005, No. 2191, § 7.

20-10-1203. Administration and management of long-term care facilities.

Every licensed facility shall comply with all applicable standards and rules of the Office of Long-Term Care and shall:

(1) Be under the administrative direction and charge of a licensed administrator;

(2) Have available the regular, consultative, and emergency services of physicians licensed by the state and required by state and federal regulations;

(3) Provide for the access of the facility residents to dental and other health-related services, recreational services, rehabilitative services, and social work services appropriate to their needs and conditions and not directly furnished by the licensee;

(4)(A) If the facility was not cited for any deficiencies in the past twelve (12) months, be encouraged by the office to provide services, including, but not limited to, respite and adult day services, which enable individuals to move in and out of the facility. A facility is not subject to any additional licensure requirements for providing these services.

(B)(i) Respite care may be offered to persons in need of short-term care services or temporary long-term care services.

(ii) Respite care shall be provided in accordance with this subchapter and rules adopted by the office. However, the office, by rule, shall adopt modified requirements for resident assessment, residential care plans, resident contracts, physician orders, and other provisions, as appropriate, for short-term care services or temporary long-term care services. The office shall allow for shared programming and staff in a facility which meets minimum standards and offers services pursuant to this subdivision (4)(B)(ii), but, if the facility is cited for deficiencies in quality of care, categories, or tags, may require additional staff and programs appropriate to the needs of service recipients.

(C)(i) A person who receives respite care may not be counted as a resident of the facility for purposes of the facility's licensed capacity unless that person receives twenty-four-hour respite care.

(ii) A person receiving either respite care for twenty-four (24) hours or longer or adult day services shall be included when calculating minimum staffing for the facility.

(D) Any costs and revenues generated by a facility from nonresidential programs or services shall be excluded from the calculations of Medicaid per diems for long-term care institutional care reimbursement;

(5) If the facility was not cited for any deficiencies in the last twelve (12) months, exceeds minimum staffing standards, and is part of a retirement community that offers other services pursuant to Part III, Part IV, or Part V, be allowed to share programming and staff;

(6) Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner;

(7)(A) If the licensee furnishes food service, provide a wholesome and nourishing diet sufficient to meet generally accepted standards of proper nutrition for its residents and provide such therapeutic diets as may be prescribed by attending physicians.

(B) In making rules to implement this subdivision (7), the office shall be guided by standards recommended by nationally recognized professional groups and associations with knowledge of dietetics;

(8)(A) Keep full records of resident admissions and discharges, medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the residents, and individual residential care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals.

(B) The records shall be open to inspection by the office;

(9) Keep such fiscal records of its operations and conditions as may be necessary to provide information pursuant to this subchapter; and

(10)(A) Furnish copies of personnel records for employees affiliated with such a facility to any other facility licensed by this state requesting this information pursuant to this subchapter. The information contained in the records may include, but is not limited to, disciplinary matters and any reason for termination.

(B) Any facility releasing such records pursuant to this subchapter shall be considered to be acting in good faith and may not be held liable for information contained in such records, absent a showing that the facility maliciously falsified such records.

History. Acts 1999, No. 1181, § 6.

CASE NOTES

Cited: Northport Health Servs. v. Owens, 356 Ark. 630, 158 S.W.3d 164 (2004).

20-10-1204. Residents' rights.

(a) All long-term care facilities shall adopt and make public a statement of the rights and responsibilities of the residents of the facilities and shall treat the residents in accordance with the provisions of that statement. The statement shall assure each resident of the following:

(1) The right to be fully informed in writing and orally, before or at the time of admission and during his or her stay, of services available in the facility and of related charges for such services, including any charges for services not covered under Title XVIII or Title XIX of the Social Security Act or not covered by the basic per diem rates and of bed reservation and refund policies of the facility;

(2) The right to examine at any time the results which the facility shall post of the most recent inspection of the facility conducted by a

federal or state agency and any plan of correction in effect with respect to the facility;

(3) The right to have copies of the rules and regulations of the facility and an explanation of the responsibility of the resident to obey all reasonable rules and regulations of the facility and to respect the personal rights and private property of the other residents;

(4)(A) The right to manage his or her own financial affairs or to delegate that responsibility to the licensee but only to the extent of the funds held in trust by the licensee for the resident.

(B) The facility may not require a resident to deposit personal funds with the facility.

(C) However, upon written authorization of a resident, the facility shall hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility as follows:

(i) The facility shall establish and maintain a system that ensures a full, complete, and separate accounting, according to generally accepted accounting principles or regulations established by the Office of Long-Term Care, of each resident's personal funds entrusted to the facility on the resident's behalf;

(ii) The accounting system established and maintained by the facility shall preclude any commingling of resident funds with facility funds or with the funds of any person other than a resident;

(iii) An annual accounting of any transaction made on behalf of the resident shall be furnished to the resident or the person responsible for the resident; and

(iv) The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Title XVIII or Title XIX of the Social Security Act.

(D) An annual accounting of any transactions made on behalf of the resident shall be furnished to the resident or to the person responsible for the resident;

(5)(A) The right to freedom of choice in selecting a personal physician, to obtain pharmaceutical supplies and services from a pharmacy of the resident's choice, at the resident's own expense or through Title XIX of the Social Security Act, and to obtain information about and to participate in community-based activities programs, unless medically contraindicated as documented by a physician in the resident's medical record.

(B)(i) If a resident chooses to use a community pharmacy and if the facility in which the resident resides uses a unit-dose system, the pharmacy selected by the resident shall be one that provides a compatible unit-dose system, provides service delivery, and stocks the drugs normally used by long-term care residents.

(ii) If a resident chooses to use a community unit-dose system and if the facility in which the resident resides does not use a unit-dose system, the pharmacy selected by the resident shall be one that provides service delivery and stocks the drugs normally used by long-term care residents;

(6) The right to be adequately informed of his or her medical condition and proposed treatment unless the resident is determined to be unable to provide informed consent under Arkansas law, the right to be fully informed in advance of any nonemergency changes in care or treatment that may affect the resident's well-being, and except with respect to a resident adjudged incompetent, the right to participate in the planning of all medical treatment, including the right to refuse medication and treatment unless otherwise indicated by the resident's physician and to know the consequences of such actions;

(7)(A)(i) The right to refuse medication or treatment and to be informed of the consequences of such decisions unless determined unable to provide informed consent under state law.

(ii) When the resident refuses medication or treatment, the facility shall notify the resident or the resident's legal representative of the consequences of such a decision and shall document the resident's decision in his or her medical record.

(B) The facility shall continue to provide other services the resident agrees to in accordance with the residential care plan;

(8) The right to receive adequate and appropriate health care and protective and support services, including social services, mental health services if available, planned recreational activities, and therapeutic and rehabilitative services consistent with the residential care plan, with established and recognized practice standards within the community, and with rules as adopted by the office;

(9) The right to have privacy in treatment and in caring for personal needs, to close room doors and to have facility personnel knock before entering the room except in the case of an emergency or unless medically contraindicated, and to security in storing and using personal possessions. Privacy of the resident's body shall be maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance;

(10) The right to receive notice before the room of the resident in the facility is changed;

(11)(A) The right to be informed of the bed reservation policy for a hospitalization.

(B)(i) The facility shall inform a private-pay resident and his or her responsible party that his or her bed will be reserved for any single hospitalization for a period up to thirty (30) days, provided that the facility receives reimbursement.

(ii) Any resident who is a recipient of assistance under Title XIX of the Social Security Act or the resident's designee or legal representative shall be informed by the licensee that his or her bed for which there is Title XIX reimbursement available will be reserved up to five (5) days but that the bed will not be reserved if it is medically determined by a physician that the resident will not need it or will not be able to return to the facility or if the office determines that the facility's occupancy rate ensures the availability of a bed for the resident.

(C) Notice shall be provided within twenty-four (24) hours of hospitalization;

(12)(A) The right to be transferred or discharged only for medical reasons or for the welfare of other residents and the right to be given reasonable advance notice of no less than thirty (30) days of any involuntary transfer or discharge, except in the case of an emergency as determined by a licensed professional on the staff of the facility or in the case of conflicting rules and regulations which govern Title XVIII or Title XIX of the Social Security Act.

(B) For nonpayment of a bill for care received, the resident shall be given thirty (30) days' advance notice.

(C)(i) A licensee certified to provide services under Title XIX of the Social Security Act may not transfer or discharge a resident solely because the source of payment for care changes.

(ii) Admission to a facility operated by a licensee may not be conditioned upon a waiver of such a right, and any document or provision in a document which purports to waive or preclude such a right is void and unenforceable.

(iii) Any licensee certified to provide services under Title XIX of the Social Security Act that obtains or attempts to obtain such a waiver of a resident's rights as established herein is subject to disciplinary action as provided in subsection (c) of this section.

(D) The resident and the family or representative of the resident shall be consulted in choosing another facility;

(13) For residents of Medicaid-certified or Medicare-certified facilities, the right to challenge a decision by the facility to discharge or transfer the resident, as required under 42 C.F.R. § 483.204;

(14)(A) The right to be free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency.

(B)(i) In the case of an emergency, restraint may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint, and in the case of use of a chemical restraint, a physician shall be consulted immediately thereafter.

(ii) Restraints may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety;

(15)(A) The right to retain and use personal clothing and possessions as space permits unless to do so would infringe upon the rights of other residents or unless medically contraindicated as documented in the resident's medical record by a physician.

(B) If clothing is provided to the resident by the licensee, it shall be of reasonable fit;

(16)(A)(i) The right to private and uncensored communication, including, but not limited to, receiving and sending unopened corre-

spondence, access to a telephone, visiting with any person of the resident's choice during visiting hours, provided that such visitors are not disruptive or dangerous, and overnight visitation outside the facility with family and friends in accordance with facility policies, physician orders, and Title XVIII and Title XIX of the Social Security Act regulations, without the resident's losing his or her bed. Facility visiting hours shall be flexible, taking into consideration special circumstances such as, but not limited to, out-of-town visitors and working relatives or friends.

(ii) Unless otherwise indicated in the residential care plan, the licensee, with the consent of the resident and in accordance with policies approved by the office, shall permit access by recognized volunteer groups, representatives of community-based legal, social, mental health, and leisure programs, and members of the clergy to the facility during visiting hours for the purpose of visiting with and providing services to any resident. Any entity or individual that provides health, social, legal, or other services to a resident has the right to have reasonable access to the resident.

(B) The resident has the right to deny or withdraw consent to access at any time by any entity or individual.

(C) Notwithstanding the visiting policy of the facility, the following individuals shall be permitted immediate access to the resident:

(i) Any representative of the federal or state government, including, but not limited to, representatives of the Department of Human Services, any law enforcement officer, any ombudsman, and the resident's individual physician; and

(ii) Subject to the resident's right to deny or withdraw consent, immediate family or other relatives of the resident;

(17)(A)(i) The right to present grievances on behalf of himself or herself or others to the staff or administrator of the facility, to governmental officials, or to any other person, to recommend changes in policies and services to facility personnel, and to join with other residents or individuals within or outside the facility to work for improvements in resident care, freedom from restraint, interference, coercion, discrimination, or reprisal. This right includes access to ombudsmen and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(ii) The facility shall allow any ombudsman to examine a resident's clinical records with the permission of the resident or the resident's legal representative and consistent with state law.

(B) The right also includes the right to prompt efforts by the facility to resolve resident grievances, including grievances with respect to the behavior of other residents;

(18) The right to organize and participate in resident groups in the facility and the right to have the resident's family meet in the facility with the families of other residents;

(19) The right to participate in social, religious, and community activities that do not interfere with the rights of other residents;

(20) The right to civil and religious liberties, including knowledge of available choices and the right to independent personal decisions which will not be infringed upon and the right to encouragement and assistance from the staff of the facility in the exercise of these rights; and

(21) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those required to be offered on an as-needed basis.

(b)(1)(A) The licensee for each long-term care facility shall orally inform the resident of the resident's rights and provide a copy of the statement required by subdivision (a)(21) of this section to each resident or the resident's legal representative at or before the resident's admission to a facility.

(B) The written statement of rights shall include a statement that a resident may file a complaint with the office or the ombudsman.

(C) The statement shall be in boldface type and shall include the name, address, and telephone numbers of the ombudsman and adult abuse registry where complaints may be lodged.

(2)(A) The licensee shall provide a copy of the residents' rights to each staff member of the facility.

(B) Each such licensee shall prepare a written plan and provide appropriate staff training to implement the provisions of this section.

(c)(1) Any violation of the residents' rights set forth in this section may constitute grounds for action by the office.

(2) In order to determine whether the licensee is adequately protecting residents' rights, the annual inspection of the facility shall include private, informal conversations with a sample of residents to discuss residents' experiences within the facility with respect to rights specified in this section and general compliance with standards and consultation with the ombudsman in the area in which the long-term care facility is located.

(d) Any person who submits or reports a complaint concerning a suspected violation of the residents' rights or concerning services or conditions in a facility or who testifies in any administrative or judicial proceeding arising from the complaint shall have immunity from civil liability thereof unless that person has acted in bad faith or with malicious purpose or if the court finds that there was a complete absence of a justiciable issue of either law or fact.

History. Acts 1999, No. 1181, § 3.

U.S. Code. Titles XVIII and XIX of the Social Security Act, referred to in this

section, are codified as 42 U.S.C. § 1395 et seq. and 42 U.S.C. § 1396 et seq., respectively.

CASE NOTES

Dignity.

Trial court erred in a medical malpractice action in permitting a personal repre-

sentative's expert to testify as to the meaning of dignity, as it was used in subdivision (a)(21) of this section; the

word dignity, simply because it was part of the statute, was not complex and did not mean something different than its ordinary and usually accepted meaning in

common language. *Bedell v. Williams*, 2012 Ark. 75, 386 S.W.3d 493 (2012).

Cited: *Northport Health Servs. v. Owens*, 356 Ark. 630, 158 S.W.3d 164 (2004).

20-10-1205. Property and personal affairs of residents.

(a)(1) The admission of a resident to a long-term care facility and his or her presence in the facility shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident, nor shall the admission or presence confer on any of the aforementioned persons any authority or responsibility for the personal affairs of the resident except that which may be necessary for the safety of the residents and the orderly management of the facility.

(2) No licensee, owner, administrator, employee, or representative thereof shall act as guardian, trustee, or conservator for any resident of the facility or any such resident's property unless the person is the resident's spouse or blood relative within the third degree of consanguinity or if so ordered by a court before July 30, 1999.

(b)(1) A licensee shall provide for the safekeeping of personal effects, funds, and other property of the resident in the facility.

(2) Whenever necessary for the protection of valuables or in order to avoid unreasonable responsibility therefor, the licensee may require that valuables be excluded or removed from the facility and kept at some place not subject to the control of the licensee.

(3) A licensee shall keep complete and accurate records of all funds and other effects and property of its residents received by the licensee for safekeeping.

(4) Any funds or other property belonging to a resident that are received by a licensee shall be held in trust. Funds held in trust:

(A) Shall be kept separate from the funds and property of the facility;

(B) Shall be deposited into a bank, savings and loan association, trust company, or credit union located in this state and, if possible, located in the same county in which the facility is located;

(C) Shall not be represented as part of the assets of the facility on a financial statement; and

(D) Shall be used or otherwise expended only for the account of the resident.

(c)(1) The licensee may enter into a self-insurance agreement as specified in rules adopted by the Office of Long-Term Care.

(2) Funds contained in the self-insurance pool shall run to any resident suffering financial loss as a result of the violation by the licensee of the provisions of this section. Such funds shall be awarded to any resident in an amount equal to the amount that the resident can establish by affidavit or other adequate evidence was deposited in trust with the licensee and which could not be paid to the resident within thirty (30) days of the resident's request.

(3)(A) The office shall promulgate rules with regard to the establishment, organization, and operation of such self-insurance pools.

(B) The rules shall include, but shall not be limited to, requirements for monetary reserves to be maintained by the self-insurers to assure their financial solvency.

(d)(1)(A) If at any time during the period for which a license is issued, a licensee that has not entered into a self-insurance agreement, as provided in subsection (c) of this section, is requested to provide safekeeping for the personal funds of a resident, the licensee shall notify the office of the request and make application for a surety bond or for participation in a self-insurance agreement within seven (7) days of the request, exclusive of weekends and holidays.

(B) Copies of the application, along with written documentation of related correspondence with an insurance agency or group, shall be maintained by the licensee for review by the office and the ombudsman.

(2) Moneys or securities received as advance payment for care may not at any time exceed the cost of care for a six-month period.

(3) At least annually, the licensee shall furnish the resident and the guardian, trustee, or conservator, if any, for the resident a complete and verified statement of all funds and other property to which this subsection applies, detailing the amounts and items received, together with their sources and disposition. In any event, the licensee shall furnish such a statement annually and upon the discharge or transfer of a resident.

(e)(1)(A)(i) In the event of the death of a resident, a licensee within thirty (30) days of the resident's death shall provide an accounting and shall return all refunds and funds held in trust to the resident's personal representative, if one has been appointed at the time that the long-term care facility disburses such funds and, if not, to the resident's spouse or a beneficiary named in a beneficiary designation form provided by the long-term care facility to the resident.

(ii) No licensee, owner, administrator, employee, or representative of a long-term care facility shall be named as a beneficiary to a resident's funds.

(iii) A beneficiary designation form shall be completed only by the resident at the time of admission to a long-term care facility and in the presence of two (2) witnesses who shall affix their signatures to the form as witnesses.

(B) If the resident has no spouse or a named beneficiary or the person cannot be located, funds due to the resident shall be placed in an interest-bearing account in a bank, savings and loan association, trust company, or credit union located in this state and, if possible, located within the same county in which the facility is located. The funds shall not be represented as part of the assets of the facility on a financial statement, and the licensee shall maintain the account until such time as the trust funds are disbursed pursuant to the provisions of the Probate Code, § 28-1-101 et seq.

(2)(A) All other property of a deceased resident being held in trust by the licensee shall be returned to the resident's personal representative, if one has been appointed at the time that the facility disburses such property and, if not, to the resident's spouse or a beneficiary named in a beneficiary designation form provided by the facility to the resident.

(B) If the resident has no spouse or a named beneficiary or the person cannot be located, property being held is to be disbursed pursuant to the provisions of the Probate Code, § 28-1-101 et seq.

(f)(1) The trust funds and property of deceased residents shall be kept separately from the funds and the property of the licensee and from the funds and property of the residents of the facility.

(2)(A) The long-term care facility needs to maintain only one (1) account in which the trust funds amounting to less than one hundred dollars (\$100) of deceased residents are placed.

(B) However, it shall be the obligation of the long-term care facility to maintain adequate records to permit compilation of interest due each individual resident's account.

(3) Separate accounts shall be maintained with respect to trust funds of deceased residents equal to or in excess of one hundred dollars (\$100).

(4) Any other property of a deceased resident held in trust by a licensee which is not disbursed in accordance with the Probate Code, § 28-1-101 et seq., shall escheat to the state as provided by law.

History. Acts 1999, No. 1181, § 7;
2001, No. 928, § 1; 2003, No. 1473, § 36.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of assembly, Public Health and Welfare, 24 U. Legislation, 2001 Arkansas General As- Ark. Little Rock L. Rev. 557.

20-10-1206. Right of entry and inspection.

(a)(1) The Department of Human Services and any duly designated officer or employee thereof or an ombudsman shall have the right to enter upon and into the premises of any long-term care facility at any time in order to determine the state of compliance with this subchapter and the rules in force pursuant to this subchapter.

(2) The right of entry and inspection shall also extend to any premise which the department has reason to believe is being operated or maintained as a facility without a license, but no such entry or inspection of any premises shall be made without the permission of the owner or person in charge thereof, unless an inspection order is first obtained from a circuit court upon a showing of reasonable cause to inspect that certain premises are being maintained and operated in violation of this subchapter and statutory licensure requirements.

(b) Any records of a long-term care facility determined by the Office of Long-Term Care to be necessary and essential to establish lawful

compliance with any rules or standards shall be made available to the office on the premises of the facility, with the exception of quality assurance committee records.

History. Acts 1999, No. 1181, §§ 8, 9.

20-10-1207. Availability, distribution, and posting of reports and records.

(a) Within ten (10) days after the date of an annual inspection visit or within thirty (30) days after the date of any interim visit, the Office of Long-Term Care shall forward the results of all inspections of long-term care facilities to:

(1) The ombudsman in whose county the inspected facility is located; and

(2) At least one (1) public library or in the absence of a public library, the county clerk in the county in which the inspected facility is located.

(b) Every long-term care facility licensee shall:

(1) Post in a sufficient number of prominent positions in the facility so as to be accessible to all residents and to the general public the last inspection report or survey pertaining to the facility and issued by the office, with references to the page numbers of the full reports, noting any deficiencies found by the office and the actions taken by the licensee to rectify such deficiencies; and

(2) Upon request, provide to any person who has completed a written application with an intent to be admitted, to any resident of the long-term care facility, or to any relative, spouse, or guardian of the person a copy of the last inspection report pertaining to the long-term care facility and issued by the office, provided that the person requesting the report agrees to pay a reasonable charge to cover copying costs.

(c)(1) Each long-term care facility licensee shall maintain as public information, available upon request, records of inspection reports pertaining to that facility that have been filed with or issued by any governmental agency.

(2) Copies of the reports shall be retained in the records for not less than five (5) years after the date the reports are filed or issued.

History. Acts 1999, No. 1181, § 9.

20-10-1208. Patient records — Penalties for alteration.

(a) Any person who fraudulently alters, defaces, or falsifies any medical or other long-term care facility record or causes or procures any of these offenses to be committed commits a Class A misdemeanor.

(b) A conviction under this section is also grounds for restriction, suspension, or termination of license privileges for the person.

History. Acts 1999, No. 1181, § 5.

20-10-1209. Civil enforcement.

(a)(1) Any resident who is injured by a deprivation or infringement of his or her rights as specified in this subchapter may bring a cause of action under § 16-114-201 et seq., against any licensee responsible for the deprivation or infringement.

(2) The action may be brought by the resident or his or her guardian or by the personal representative of the estate of a deceased resident.

(3) The action may be brought in any court of competent jurisdiction in the county in which the injury occurred or where the licensee is located to enforce such rights and to recover actual and punitive damages.

(4) The resident may seek to recover actual damages when there is a finding that an employee of the long-term care facility failed to do something which a reasonably careful person would do or did something which a reasonable person would not do under circumstances similar to those shown by the evidence in the case, which caused an injury due to an infringement or a deprivation of the resident's rights.

(5) No separate award of attorney's fees may be made by the court.

(b)(1) A licensee shall not be liable for the medical negligence of any physician rendering care or treatment to the resident, except for the services of a medical director as required in this subchapter.

(2) Nothing in this subsection shall be construed to protect a licensee from liability for failure to provide a resident with appropriate observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care by nursing staff.

(c) For the purpose of this section, punitive damages may be awarded for conduct which is willful, wanton, gross or flagrant, reckless, or consciously indifferent to the rights of the resident.

(d)(1) A deprivation or infringement of rights under this subchapter does not itself create an additional cause of action.

(2) However, a deprivation or infringement of rights under this subchapter may be used as evidence of negligence.

History. Acts 1999, No. 1181, § 4; 2013, No. 1196, §§ 5, 6.

A.C.R.C. Notes. Acts 2013, No. 1196, § 1, provided: "Intent — Limitation.

"(a) This act is intended to ensure that:

"(1) A person who suffers a medical injury has the opportunity to seek compensation to return to the state of health that he or she enjoyed before the medical injury; and

"(2) For any one (1) medical injury, a person is not compensated more than once.

"(b) This act is not intended to affect punitive damages."

Amendments. The 2013 amendment inserted "under § 16-114-201 et seq." in (a)(1); and added (d).

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Health Law — The Arkansas Resident's Rights Statute and Civil Enforcement — Cutting Off Its Nose To Spite Its Face: How the

Arkansas Resident's Rights Statute Is Defeating Its Purpose of Improving Quality of Care to Nursing Home Residents by Crippling the Nursing Homes Them-

selves. Health Facilities Management Corp. v. Hughes, 29 U. Ark. Little Rock L. Rev. 597.

CASE NOTES

ANALYSIS

In General.
Construction.
Directed Verdict.
Jury Instructions.

In General.

Judgment in favor of executrix of deceased nursing home facility resident's estate on claims brought under subdivision (a)(1) of this section against a management company and nursing home facility was reversed as to the management company because no license was issued to the management company; thus, under the plain language of § 20-10-224, the management company was not a licensee subject to suit for violation of the resident's rights. Health Facilities Mgmt. Corp. v. Hughes, 365 Ark. 237, 227 S.W.3d 910 (2006) (decision under former law).

Construction.

Jury verdict in favor of nursing home facility on the medical malpractice and wrongful death claims did not exonerate it from wrongdoing under the Arkansas Long-Term Care Facilities Code, § 20-10-224; even though the causes of action were tried together, the resident's-rights claim under subdivision (a)(1) of this section

was a statutory claim separate and apart from the common-law claim of ordinary negligence, and the jury was entitled to reach conflicting results in relation to those claims. Health Facilities Mgmt. Corp. v. Hughes, 365 Ark. 237, 227 S.W.3d 910 (2006) (decision under former law).

Directed Verdict.

Directed verdict was appropriate in a case alleging a violation of the Arkansas Resident's Rights Act, even though it was not subsumed in a medical malpractice claim, because co-administrators made only conclusory arguments that they proffered sufficient evidence relating to proximate cause. They did not point to any evidence linking the alleged violations to a resident's death or injuries. Smith v. Heather Manor Care Ctr., Inc., 2012 Ark. App. 584, 424 S.W.3d 368 (2012) (decision under former law).

Jury Instructions.

Trial court erred in a medical malpractice action in not including in an instruction to the jury the causation element required in subsection (a) of this section when damages were sought for a violation of a nursing home resident's rights. Bedell v. Williams, 2012 Ark. 75, 386 S.W.3d 493 (2012) (decision under former law).

SUBCHAPTER 13 — NURSING HOME RESIDENT AND EMPLOYEE IMMUNIZATION ACT OF 1999

SECTION.

20-10-1301. Title.
20-10-1302. Purpose.
20-10-1303. Definitions.

SECTION.

20-10-1304. Implementation.
20-10-1305. Exemptions.

20-10-1301. Title.

This subchapter shall be known and may be cited as the "Nursing Home Resident and Employee Immunization Act of 1999".

History. Acts 1999, No. 1524, § 1; 2007, No. 827, § 154.

20-10-1302. Purpose.

It is recognized that:

(1) The sixth leading cause of death in Arkansas is the combined diagnostic category of pneumonia and influenza;

(2) Approximately ninety percent (90%) of the pneumonia and influenza deaths are in those over sixty-five (65) years of age;

(3) The Centers for Disease Control and Prevention recommends that individuals over the age of sixty-five (65) years have annual flu shots and a pneumococcal vaccine one (1) time;

(4) The Centers for Disease Control and Prevention further suggests that consent for immunization be acquired at the time of nursing home admission;

(5) Current utilization of the flu shots by nursing home residents is approximately fifty percent (50%);

(6) The elderly living in an institutional setting, where disease may be more readily transmitted, are less protected than those living in the community; and

(7) The pneumococcal vaccine utilization by nursing home residents is approximately thirty percent (30%).

History. Acts 1999, No. 1524, § 2.

20-10-1303. Definitions.

As used in this subchapter:

(1) "Document" means evidence from a person's physician or health-care provider in written format indicating the date and place when the individual received the influenza virus vaccine and the pneumococcal pneumonia vaccine;

(2) "Medically contraindicated" means either that the influenza or pneumococcal vaccines should not be administered to an individual because of a condition that individual has that will be detrimental to the individual's health if the individual receives either of the vaccines;

(3)(A) "Nursing home facilities" means facilities that include any building, structure, agency, institution, or place for the reception, accommodation, board, care, or treatment of two (2) or more individuals who because of physical or mental infirmity are unable to sufficiently or properly care for themselves and for which reception, accommodation, board, care, or treatment a charge is made.

(B) "Nursing home" shall not include the offices of private physicians and surgeons, residential healthcare facilities, hospitals, institutions operated by the United States Government, any other similar facility where individuals reside, or any facility which is conducted by and for those who rely exclusively upon treatment by prayer alone for healing in accordance with the tenets or practices of any recognized religious denomination; and

(4) "Report" means to maintain a current list or roster of vaccine status for residents and employees and by December 1 of each year to provide that list to the Office of Long-Term Care.

History. Acts 1999, No. 1524, § 3.

20-10-1304. Implementation.

(a)(1)(A) The State Board of Health may promulgate rules and regulations to provide for the immunization against the influenza virus and pneumococcal disease as provided for in this subchapter.

(B) The Office of Long-Term Care shall be granted authority to enforce the rules and regulations.

(2) The board may also promulgate rules and regulations to provide for the immunization of other individuals and require other institutions and facilities to provide the immunizations provided for in this subchapter.

(b) Each nursing home facility in this state shall:

(1) Obtain consent from residents or their legal guardians upon admission to participate in all immunization programs that are conducted within the facility while that person is a resident of that facility, and not in violation of the resident's right to refuse treatment;

(2) As a condition of his or her employment, require each employee to participate in immunization programs conducted while he or she is employed at the facility, unless the employee meets the qualifications for exemptions as listed in § 20-10-1305; and

(3) Document and report annually immunizations against:

(A) Influenza virus for residents and full-time and part-time employees; and

(B) Pneumococcal disease for residents.

(c) Any nursing home facility which violates this subchapter shall be subject to suspension and revocation of its license.

(d)(1) As provided in this subchapter, the Department of Health shall provide vaccines, supplies, and staff necessary for the immunizations of nursing home residents and employees that lack coverage for immunizations through Medicare, Medicaid, or other health insurance.

(2) However, during the outbreak of a pandemic disease, the department may enforce vaccine priorities necessary to limit the loss of life among citizens and to contain the spread of the disease.

History. Acts 1999, No. 1524, § 4; 2007, No. 815, § 1; 2015, No. 1051, § 1.

Amendments. The 2015 amendment, in (d)(1), added "As provided in this subchapter", deleted "as provided for in this

subchapter" following "employees", and added "that lack coverage for immunizations through Medicare, Medicaid, or other health insurance".

20-10-1305. Exemptions.

All residents of nursing home facilities and all full-time and part-time employees of nursing home facilities shall be immunized according to this subchapter with the following exemptions:

(1) No individual shall be required to receive either an influenza virus vaccine or a pneumococcal pneumonia vaccine if the vaccine is

medically contraindicated as described in the product labeling approved by the United States Food and Drug Administration; and

(2) The provisions of this subchapter shall not apply if the resident or legal guardian objects on the grounds that the immunization conflicts with the religious tenets and practices of a recognized church or religious denomination of which the resident or guardian is an adherent or member.

History. Acts 1999, No. 1524, § 5; 2007, No. 827, § 155.

SUBCHAPTER 14 — STAFFING REQUIREMENTS FOR NURSING FACILITIES

SECTION.

- 20-10-1401. Definitions.
- 20-10-1402. Staffing standards.
- 20-10-1403. Ratio of staff to residents.
- 20-10-1404. Director of nurses.
- 20-10-1405. Services provided.
- 20-10-1406. Posting of personnel numbers.

SECTION.

- 20-10-1407. Report.
- 20-10-1408. Penalties.
- 20-10-1409. Staffing standards — Definition.
- 20-10-1410. Cosmetology and barbering services.

Effective Dates. Acts 1999, No. 1529, § 13: Apr. 15, 1999. Emergency clause provided: “It is hereby found and determined by the Eighty-second General Assembly that the provisions of this Act are of critical importance to preserve the efficient operation of programs that deliver services to the elderly citizens of the State of Arkansas. It is vital that we ensure that those persons in nursing facilities and nursing homes enjoy a high quality of life. The Department of Finance and Administration shall be required to make a determination on June 30, 1999 as to the funds available to administer the provisions of this Act. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto.”

Acts 2003, No. 1473, § 74: July 1, 2003. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act

includes technical corrects to Act 923 of 2003 which establishes the classification and compensation levels of state employees covered by the provisions of the Uniform Classification and Compensation Act; that Act 923 of 2003 will become effective on July 1, 2003; and that to avoid confusion this act must also effective on July 1, 2003. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2003.”

Acts 2005, No. 2191, § 11: Apr. 13, 2005. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that various long-term care facilities are operating in this state without having obtained a license; that there is no state oversight or protection for the vulnerable residents in these facilities; and that there is no way of ensuring that the facilities properly treat and protect these residents under state long-term care laws. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period

of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

20-10-1401. Definitions.

As used in this subchapter:

- (1) “Day shift” means the period of 7:00 a.m. to 3:00 p.m.;
- (2)(A) “Direct-care staff” means any nurse aide or licensed nurse who provides direct, hands-on care to nursing facility residents.
 - (B) “Direct-care staff” shall not include:
 - (i) Therapy personnel or personnel listed in § 20-10-1404; or
 - (ii) Medication assistive persons as defined in § 17-87-701;
- (3) “Evening shift” means the period of 3:00 p.m. to 11:00 p.m.;
- (4) “Midnight census” means the number of patients occupying nursing home beds in a nursing facility at midnight of each day;
- (5) “Night shift” means the period of 11:00 p.m. to 7:00 a.m.;
- (6) “Nurse aide” means any person who meets the requirements according to regulations adopted pursuant to 42 C.F.R. § 483.75(e), as it existed on January 1, 2005; and
- (7)(A) “Nursing facility” means any building, structure, agency, institution, or other place for the reception, accommodation, board, care, or treatment of more than three (3) unrelated individuals who, because of physical or mental infirmity, are unable to sufficiently or properly care for themselves, and for which reception, accommodation, board, care, and treatment a charge is made.
 - (B) However, “nursing facility” shall not include:
 - (i) The offices of private physicians and surgeons;
 - (ii) Residential care facilities;
 - (iii) Assisted living facilities;
 - (iv) Intermediate care facilities for individuals with developmental disabilities;
 - (v) Hospitals;
 - (vi) Institutions operated by the United States Government or licensed by the Division of Developmental Disabilities Services of the Department of Human Services; or
 - (vii) Any facility that is conducted by and for those who rely exclusively upon treatment by prayer alone for healing in accordance with the tenets or practices of any recognized religious denomination.

History. Acts 1999, No. 1529, § 1;
 2001, No. 1397, § 1; 2005, No. 1411, § 1;
 2005, No. 1423, § 5; 2005, No. 2191, § 8.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of Arkansas General Assembly, Public Health and Welfare, 24 U. Ark. Little Rock L. Rev. 557.

20-10-1402. Staffing standards.

(a) The Department of Human Services shall not issue or renew a license of a nursing facility unless that facility employs the direct-care staff needed to provide continuous twenty-four-hour nursing care and service to meet the needs of each resident of the nursing facility and the staffing standards required by all state and federal regulations.

(b)(1) Except for nursing facilities that the Office of Long-Term Care designates or certifies as Eden Alternative nursing facilities or Green House Project nursing facilities, the staffing standard required by this subchapter shall be the minimum number of direct-care staff required by nursing facilities and shall be adjusted upward to meet the care needs of residents.

(2)(A) The office shall promulgate staffing standards for nursing facilities that the office designates or certifies as Eden Alternative nursing facilities or Green House Project nursing facilities.

(B) The department may develop a reimbursement methodology or amend the reimbursement methodology in existence as of July 31, 2007, to provide payment for staff that provides services or care to residents in the designated or certified Eden Alternative nursing facilities or Green House Project nursing facilities.

(c) If a facility varies shift hours from the shift hours listed in § 20-10-1401, the facility shall meet the staffing requirements for the shift listed in § 20-10-1403.

History. Acts 1999, No. 1529, § 2;
2001, No. 1397, § 2; 2005, No. 1411, § 2;
2007, No. 192, § 1.

20-10-1403. Ratio of staff to residents.

(a) Except for nursing facilities that the Office of Long-Term Care designates as Eden Alternative nursing facilities or Green House Project nursing facilities, all nursing facilities shall maintain the following minimum direct-care staffing-to-resident ratios:

(1) One (1) direct-care staff to every six (6) residents for the day shift. Of this direct-care staff, there shall be at least one (1) licensed nurse to every forty (40) residents;

(2) One (1) direct-care staff to every nine (9) residents for the evening shift. Of this direct-care staff, there shall be at least one (1) licensed nurse to every forty (40) residents; and

(3) One (1) direct-care staff to every fourteen (14) residents for the night shift. Of this direct-care staff, there shall be at least one (1) licensed nurse to every eighty (80) residents.

(b)(1) Licensed direct-care staff shall not be excluded from the computation of the ratios of direct-care staff to residents while serving in a staffing capacity that requires less education and training than is commensurate with their professional licensure.

(2) Licensed direct-care staff who serve in a staffing capacity that requires less education and training than is commensurate with their

professional licensure shall not be restricted from providing direct-care services within the scope of their professional licensure in order to be included in the computation of the ratios of direct-care staff to residents.

(c) Nursing facilities shall provide in-service training to their direct-care staffs pursuant to regulations promulgated by the office.

(d) Upon any expansion of resident census by the facility, the facility shall be exempt from any increase in staffing ratios for a period of nine (9) consecutive shifts from the date of the expansion of resident census.

(e)(1) The computation of the direct-care minimum staffing ratios shall be carried to the hundredth place.

(2) If the application of the ratios listed in subsections (a)-(c) of this section results in other than a whole number of direct-care staff for a shift or shifts, the number of required direct-care staff shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths (.51) or higher.

(3) In no event shall a facility have fewer than one (1) licensed nurse per shift for direct-care staff.

(4) All computations shall be based on the midnight census for the day in which the shift or shifts begin.

(f)(1) Facilities may vary the starting hour and the ending hour for up to twenty-five percent (25%) of the minimum direct-care staff of the day shift or the evening shift, or both, to meet resident care needs.

(2) Before varying the starting hour and the ending hour of direct-care staff of the day shift or the evening shift, the facility shall inform the office in writing of:

(A) The resident care needs to be met by the change in starting and ending times of the shift;

(B) The number of direct-care staff to whom the changes will apply;

(C) The starting hour and ending hour of the shift for the direct-care staff to whom the change will apply; and

(D) The length of time the variations will be used, if known.

(3)(A) The facility shall receive written approval from the office before the facility may vary the starting hour and ending hour of a shift for selected direct-care staff.

(B) The office may deny approval upon determination that:

(i) The reason for the request to vary the starting and ending time of a shift for selected direct-care staff does not meet resident care needs;

(ii) The facility was in a pattern of failure for any month in the three (3) months immediately preceding the request; or

(iii) The variation will result in a period of more than two (2) hours in which there is less than the minimum required number of direct-care staff under subsection (a) of this section.

(C) The office may revoke approval to vary the starting and ending time of a shift for selected direct-care staff if the office determines that:

(i) The approval has resulted in resident care needs being unmet;
or

(ii) The facility is in a pattern of failure.

(4) If a facility varies the starting and ending times for direct-care staff of the day shift or the evening shift, or both, the facility shall be deemed to have met minimum staffing requirements for that shift if the number of direct-care staff whose starting and ending times are varied and the number of direct-care staff whose starting and ending times are not varied together equal the number of direct-care staff required for the shift.

History. Acts 1999, No. 1529, § 3;
2001, No. 1397, § 3; 2003, No. 1473, § 37;
2005, No. 1411, § 3; 2007, No. 192, § 2.

20-10-1404. Director of nurses.

(a) In addition to the minimum direct-care staffing ratios in § 20-10-1403, each nursing facility shall employ a registered nurse to serve as director of nurses.

(b)(1) The director shall be a full-time employee and shall be employed for no less than forty (40) hours per week.

(2) An additional registered nurse shall be employed for a minimum of sixteen (16) hours per week to ensure coverage seven (7) days a week.

History. Acts 1999, No. 1529, § 4;
2001, No. 1397, § 4.

20-10-1405. Services provided.

(a) An employee designated as a member of the direct-care staff shall not be required to provide services such as food preparation, housekeeping, laundry, or maintenance services except as necessary to maintain a safe and sanitary environment.

(b) Persons employed to provide additional services such as food preparation, housekeeping, laundry, or maintenance services shall not be counted in determining the staffing ratios required by this subchapter unless the persons are qualified to serve as and specifically scheduled in a direct-care capacity.

(c) A person employed to provide additional services shall count toward the direct-care staffing ratios only for the time in which the facility can document that the person provides direct-care services.

History. Acts 1999, No. 1529, § 5;
2005, No. 1411, § 4.

20-10-1406. Posting of personnel numbers.

(a)(1) Each nursing facility shall post daily at the beginning of each shift in a prominent place within twenty feet (20') of the main entrance of the nursing facility and in a location that is readily accessible and

visible to residents and visitors the number of direct-care staff on duty at each shift.

(2) The posting shall consist of a sign-in sheet signed by each staff member as the staff member reports to work, and the staff member shall indicate on the sheet the time of arrival and departure, all halls, wings, or corridors on which the staff member worked or was assigned, and the total number of hours worked.

(3) The title of the posting shall be printed in a type no smaller than 18-point type.

(4) Below the posting, the nursing facility shall post a diagram of the facility showing the location of each hall, wing, or corridor.

(b) The current number of residents shall be posted and filed with the staffing report for the same time period.

(c) These records shall be filed and saved by the nursing facility until the next survey or for eighteen (18) months, whichever is greater, and these records shall be available for review by any interested person upon a written request.

History. Acts 1999, No. 1529, § 6;
2005, No. 1411, § 5; 2007, No. 282, § 1.

20-10-1407. Report.

(a)(1) By the fifth day of each month, each nursing facility shall submit a written report of all shifts which failed to meet the minimum staffing requirements of this subchapter during the preceding month to the Office of Long-Term Care.

(2) Upon determination by the office that a pattern of failure to comply with the provisions of this subchapter has occurred, the nursing facility shall submit to the office on a monthly basis a report stating the ratios of direct-care staff to residents for each shift, in addition to the requirements set forth in subdivision (a)(1) of this section.

(3) Each nursing facility also shall submit copies of all daily staffing logs for the same months for any reports required under subdivision (a)(1) or subsection (b) of this section.

(b) The failure of a direct-care staff member or members to sign the posted sign-in sheet in accordance with § 20-10-1406 shall not be considered a violation of the staff-resident ratios set forth in § 20-10-1403 if the facility has other documentation that the staff member or members provided direct-care services for the dates and times stated by the facility.

(c) The failure to meet the requirement regarding the posting of current staff-resident ratios set forth in § 20-10-1406 or the failure to provide staffing reports, logs, or other documentation directly related to minimum staffing standards to the office or the Division of Medical Services of the Department of Human Services is a Class C violation in accordance with § 20-10-205.

(d) “Pattern of failure” means that a facility did not meet the minimum staffing requirements of this subchapter for more than twenty percent (20%) of the total number of shifts for any one (1) month.

(e)(1) The division may perform staffing audits, including random staffing audits, of nursing facilities to determine and ensure compliance with the requirements of this subchapter.

(2) Facilities shall provide staffing reports, logs, or other documentation upon request of the division.

History. Acts 1999, No. 1529, § 7; 2001, No. 1397, § 5; 2005, No. 1411, § 6.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of Legislation, 2001 Arkansas General Assembly, Public Health and Welfare, 24 U. Ark. Little Rock L. Rev. 557.

CASE NOTES

Class Action Superiority.

Class certification against nursing homes met Ark. R. Civ. P. 23 superiority because (1) whether understaffing created contractual or statutory liability and occurred were more efficiently handled in one proceeding, and (2) the involvement of

12 facilities did not make the case unmanageable, as this section required each facility to report shifts failing to meet minimum staffing requirements. GGNSC Arkadelphia, LLC v. Lamb, 2015 Ark. 253, 465 S.W.3d 826 (2015).

20-10-1408. Penalties.

(a) Upon a determination of a pattern of failure of a facility by the Office of Long-Term Care, the following penalties shall be applied to the facility:

(1) When the pattern of failure is more than twenty percent (20%) but less than twenty-five percent (25%) of the total number of shifts for any one (1) month, the facility shall be assessed a fine of two thousand five hundred dollars (\$2,500);

(2) When the pattern of failure is twenty-five percent (25%) or higher but less than thirty percent (30%) of the total number of shifts for any one (1) month, the facility:

(A) Shall be assessed a fine of five thousand dollars (\$5,000); and

(B)(i) Shall be prohibited from admitting new residents for a period of at least two (2) weeks beginning the next business day after notification by the office to the facility of the pattern of failure and continuing until the next business day after the facility submits a report establishing that the facility was not in a pattern of failure for the time during which the facility was prohibited from admitting new residents.

(ii) If the office subsequently determines that the facility did not meet the minimum staffing standards requirements as alleged in the report from the facility, the office shall prohibit the facility from admitting new residents for a period of at least two (2) weeks, and

continuing until the next business day after the facility submits a new report establishing that the facility was not in a pattern of failure for the time in which the facility was prohibited from admitting new residents;

(3) When the pattern of failure is thirty percent (30%) or higher of the total number of shifts for any one (1) month in a three-month reporting period, the facility:

(A) Shall be assessed a fine of seven thousand five hundred dollars (\$7,500); and

(B)(i) Shall be prohibited from admitting new residents for a period of at least two (2) weeks beginning the next business day after notification by the office to the facility of the pattern of failure and continuing until the next business day after the facility submits a report establishing that the facility was not in a pattern of failure for the time during which the facility was prohibited from admitting new residents.

(ii) If the office subsequently determines that the facility did not meet the minimum staffing standards requirements as alleged in the report from the facility, the office shall prohibit the facility from admitting new residents for a period of at least two (2) weeks and continuing until the next business day after the facility submits a new report establishing that the facility was not in a pattern of failure for the time in which the facility was prohibited from admitting new residents; and

(4) If after five (5) days' notice from the office of the imposition of a denial of new admissions, a facility admits new residents during a period in which the facility is prohibited from admitting new residents, the facility shall be assessed a fine of twenty-five thousand dollars (\$25,000) per new resident admitted.

(b) The penalties stated in this subchapter are supplemental to any provisions in state or federal laws or regulations.

(c) Appeals from the imposition of any remedy imposed under this subchapter shall be made pursuant to § 20-10-208.

(d)(1) When residents are relocated from facilities due to natural disaster or as a result of state or federal action, the Department of Human Services may waive some or all of the provisions of §§ 20-10-1403 and 20-10-1404 for facilities to which the residents are relocated.

(2) Any waiver shall be limited to no more than three (3) months from the date of transfer.

History. Acts 1999, No. 1529, § 8;
2001, No. 1397, § 6; 2005, No. 898, § 6;
2005, No. 1411, § 7.

20-10-1409. Staffing standards — Definition.

(a) The staffing standards as set forth in § 20-10-1403 are to be construed as nursing facility staffing standards above the 1989 standards established by the Office of Long-Term Care.

(b)(1) If the Director of the Department of Human Services determines that the reimbursement methodology or available funding is insufficient or unable to pay for the minimum staffing standards under § 20-10-1403, the office, by regulation, may modify the requirements of § 20-10-1403 to ensure minimum staffing funds.

(2) If the Director of the Office of Long-Term Care determines that the minimum staffing standards under § 20-10-1403 or § 20-10-1404 have become insufficient at any time to ensure the health, safety, or welfare of nursing facility residents, by regulation, the office may increase minimum staffing standards or otherwise promulgate regulations to ensure the health, safety, or welfare of the nursing facility residents.

(c)(1)(A) If the Director of the Office of Long-Term Care determines that minimum staffing standards should be increased pursuant to subdivision (b)(2) of this section, the Director of the Office of Long-Term Care shall certify the determination and any proposed regulatory increases to minimum staffing standards to the Director of the Division of Medical Services of the Department of Human Services, who shall notify the Director of the Department of Human Services and the Legislative Council of the determination and whether sufficient appropriated funds exist to fund the costs to be incurred by the proposed changes to the minimum staffing standards.

(B) As used in this subsection, “costs” means direct-care costs as defined in the Centers for Medicare & Medicaid Services Provider Reimbursement Manual as in effect January 12, 2001.

(2) In no event shall minimum staffing standards be increased unless sufficient appropriated funds exist to fund the costs to be incurred by the proposed increases to minimum staffing standards.

History. Acts 1999, No. 1529, § 9;
2001, No. 1397, § 7; 2003, No. 1473, § 38;
2005, No. 1411, § 8.

20-10-1410. Cosmetology and barbering services.

(a)(1) Cosmetology and barbering services provided to residents of nursing facilities and for which a fee is charged that is separate from and additional to monthly facility charges shall be provided only by a licensed cosmetologist or registered barber, respectively.

(2)(A) Routine personal hygiene and related daily care services that are provided to residents of nursing facilities and for which the fee is included in the monthly facility charges may be provided by direct-care staff who are trained, licensed, and certified through various state and federal regulatory agencies.

(B) With the exception of shampoos, conditioners, soaps, antiseptics, or similar items, routine personal hygiene and related daily care services shall not include the use of chemical or cosmetic preparations such as those used in permanent waving, bleaching, tinting, coloring, and dyeing.

(b)(1) A direct-care staff member shall not be required to hold a license as a cosmetologist or barber in order to provide routine personal hygiene and related daily care services.

(2) Nursing facilities shall be exempt from the licensure requirements for cosmetological establishments under § 17-26-401 et seq.

(3) A relative of a resident of a nursing facility providing cosmetological services to a related resident of a nursing facility shall be exempt from the following:

(A) The licensure requirements for cosmetologists under § 17-26-303; and

(B) The registration requirements for barbers under § 17-20-301 et seq.

History. Acts 2003, No. 680, § 1.

Cross References. Definition of cosmetological establishment, § 17-26-102(a)(2).

Nursing facilities staff and relatives of residents exempt from the Cosmetology Act, § 17-26-103(a).

SUBCHAPTER 15 — ALZHEIMER'S SPECIAL CARE STANDARDS ACT

SECTION.

20-10-1501. Title.

20-10-1502. Legislative findings.

20-10-1503. Applicability.

SECTION.

20-10-1504. Disclosure of treatment offered.

20-10-1505. Standards of care.

20-10-1501. Title.

This subchapter shall be known and may be cited as the "Alzheimer's Special Care Standards Act".

History. Acts 1999, No. 484, § 1.

20-10-1502. Legislative findings.

The General Assembly finds and declares that:

(1) Certain long-term care facilities claim to provide special care units and services for persons who have Alzheimer's disease or related dementia;

(2) It is in the public interest to provide for the protection of consumers regarding the accuracy and authenticity of the claims; and

(3) The provisions of this subchapter are intended to require such facilities to actually provide the care that they claim to offer, to require records of the claims to be kept, and to require the appropriate state licensing agency to examine their performance and provide penalties as the agency deems appropriate.

History. Acts 1999, No. 484, § 2; 2001, No. 500, § 1.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of assembly, Public Health and Welfare, 24 U. Legislation, 2001 Arkansas General As- Ark. Little Rock L. Rev. 557.

20-10-1503. Applicability.

For the purposes of this subchapter, a long-term care facility has an Alzheimer's special care unit if the long-term care facility advertises or otherwise holds itself out as having one (1) or more special units for residents with a diagnosis of probable Alzheimer's disease or related dementia.

History. Acts 1999, No. 484, § 3; 2001, No. 500, § 2.

20-10-1504. Disclosure of treatment offered.

(a)(1) Any facility having an Alzheimer's special care unit shall be required to disclose the form of care or treatment provided to or for persons with a diagnosis of probable Alzheimer's disease or related dementia.

(2)(A) The disclosure shall be made to the Office of Long-Term Care and to any person or the person's guardian or relative seeking placement within an Alzheimer's special care unit.

(B) The office shall examine all such disclosures as part of the facility's license renewal procedure and verify their accuracy.

(b) Each disclosure shall explain the additional care provided in each of the following areas:

(1) Treatment philosophy: The Alzheimer's special care unit's or program's written statement of its overall treatment philosophy and mission which reflects the needs of residents afflicted with dementia;

(2) Screening, admission, and discharge procedures, assessment, planning and implementation of care, staffing patterns, and training ratios unique to the unit;

(3) Physical environment and design features appropriate to support the functioning of cognitively impaired adult residents;

(4) The frequency and types of resident activities;

(5) The involvement of families and the availability of family support programs; and

(6) The costs of care and any additional fees unique to the Alzheimer's special care unit or program.

(c)(1) If a facility having an Alzheimer's special care unit does not meet those specific standards established by the office, the office shall instruct the facility to immediately cease advertising or holding itself out as having one (1) or more special programs for residents with a diagnosis of probable Alzheimer's disease or related dementia.

(2) If the facility fails or refuses to comply with instructions from the office, the office may sue in the name of the state the facility and any owner, manager, or director of the facility to enjoin the facility from

advertising or holding itself out as having one (1) or more special programs for residents with a diagnosis of probable Alzheimer’s disease or related dementia.

History. Acts 1999, No. 484, § 4; 2001, No. 500, § 3.

20-10-1505. Standards of care.

The Office of Long-Term Care shall establish and promulgate minimum standards for the care and treatment of persons with Alzheimer’s disease and other dementia in Alzheimer’s special care units.

History. Acts 1999, No. 484, § 5.

SUBCHAPTER 16 — QUALITY ASSURANCE LEVY

SECTION.

- 20-10-1601. Definitions.
- 20-10-1602. Calculation of quality assurance fee.
- 20-10-1603. Reporting and collection.
- 20-10-1604. Administration.

SECTION.

- 20-10-1605. [Repealed.]
- 20-10-1606. Waiver for nursing facilities under life-care facility contracts.

Effective Dates. Acts 2001, No. 635, § 7: Mar. 9, 2001. Emergency clause provided: “It is found and determined by the General Assembly that nursing facilities are struggling to attain the resources necessary to provide persons in the nursing facilities with the proper services they rightfully deserve. The imposition of the fee will allow nursing facilities to provide quality patient care enhancements, and therefore, ensure the safety of and a healthy environment for patients in nursing facilities. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto.”

Acts 2005, No. 2191, § 11: Apr. 13, 2005. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that various long-term care facilities are operating in this state without having obtained a license; that there is no state oversight or protection for the vulnerable residents in these facilities; and that there is no way of ensuring that the facilities properly treat and protect these residents under state long-term care laws. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

20-10-1601. Definitions.

As used in this subchapter:

(1) “Director” means the Director of the Division of Medical Services of the Department of Human Services;

(2) “Division” means the Division of Medical Services;

(3)(A) “Gross receipts” means gross receipts paid as compensation for services provided to residents of nursing facilities, including, but not limited to, client participation.

(B) “Gross receipts” does not mean charitable contributions;

(4) “Medicaid” means the medical assistance program established by Title XIX of the Social Security Act, as it existed on January 1, 2001, and administered by the Division of Medical Services;

(5) “Midnight census” means the count of:

(A) Each patient occupying a nursing facility bed at midnight of each day;

(B) Those beds placed on hold during a period of time not to exceed five (5) consecutive calendar days during which a patient is in a hospital bed; and

(C) Those beds placed on hold during a period of time not to exceed fourteen (14) consecutive calendar days during which a patient is on therapeutic home leave;

(6) “Multiplier” means the fixed dollar amount used to calculate the quality assurance fee;

(7)(A) “Nursing facilities” means any buildings, structures, agencies, institutions, or other places which require payment for the reception, accommodation, board, care, or treatment of more than three (3) unrelated individuals who due to a physical or mental infirmity are unable to care for themselves.

(B) “Nursing facilities” does not mean offices of private physicians and surgeons, residential care facilities, assisted living facilities, intermediate care facilities for individuals with developmental disabilities, hospitals, institutions operated by the United States Government or licensed by the Division of Developmental Disabilities Services within the Department of Human Services, or any facility which is conducted by and for those who rely exclusively upon treatment by prayer for healing in accordance with tenets or practices of any recognized religious denomination; and

(8) “Patient days” means the number of patients in a nursing facility as determined by the midnight census.

History. Acts 2001, No. 635, § 1; 2005, No. 2191, § 9. Security Act, referred to in this section, is codified as 42 U.S.C. § 1396 et seq.

U.S. Code. Title XIX of the Social

20-10-1602. Calculation of quality assurance fee.

(a) There is levied a quality assurance fee on nursing facilities to be calculated in accordance with subsection (b) of this section.

(b)(1) The quality assurance fee shall be an amount determined each month by multiplying the patient days, as reported by each nursing facility for each day of the month, by the multiplier.

(2) Each multiplier shall be:

(A) Calculated by the Division of Medical Services within the Department of Human Services to produce an aggregate annual quality assurance fee payment equal to six percent (6%) of the aggregate annual gross receipts; and

(B) Subject to prospective adjustment as necessary for annual aggregate quality assurance payments to equal six percent (6%) of the aggregate annual gross receipts.

(c)(1) Between March 9, 2001, and June 30, 2001, the multiplier shall be five dollars and twenty-five cents (\$5.25).

(2)(A) On and after July 1, 2001, and annually thereafter, the multiplier shall be determined using the patient days and gross receipts reported to the division for a period of at least six (6) months and shall be annualized.

(B) The division shall determine the six-month period to be used in order to calculate the multiplier.

History. Acts 2001, No. 635, § 2.

20-10-1603. Reporting and collection.

(a) On the tenth day of the first full month following March 9, 2001, and on the tenth day of each month thereafter, each nursing facility shall file a report with the Division of Medical Services within the Department of Human Services listing the patient days for the preceding month.

(b) The quality assurance fee shall be due and payable for the previous month by the thirtieth of each month.

(c) The payment of the quality assurance fee by the nursing facilities shall be reported as an allowable cost for Medicaid reimbursement purposes.

History. Acts 2001, No. 635, § 3.

20-10-1604. Administration.

(a) The administration of this subchapter shall be exercised by the Director of the Division of Medical Services of the Department of Human Services and shall be subject to the provisions of the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(b)(1) In accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq., the Division of Medical Services shall promulgate rules and regulations and prescribe forms for:

(A) The proper imposition and collection of the quality assurance fee;

(B)(i) The enforcement of this subchapter, including, but not limited to, license nonrenewal, letters of caution, sanctions, or fines.

(ii) The fine shall be at least ten thousand dollars (\$10,000) but no more than twenty thousand dollars (\$20,000). The fine and outstanding quality assurance fee shall accrue interest at the maximum rate permitted by law from the date the quality assurance fee is due until payment of the quality assurance fee and the fine;

(C) The format for reporting by all nursing homes the total patient days and gross receipts; and

(D) The administration of the provisions of this subchapter.

(2) The rules and regulations shall not grant any exceptions to, or exceptions from, the quality assurance fee.

(c)(1) The quality assurance fee assessed and collected pursuant to this subchapter shall be assessed and deposited as a designated account within the Arkansas Medicaid Program Trust Fund.

(2) The designated account shall be separate and distinct from the general fund and shall be supplementary to the Arkansas Medicaid Program Trust Fund.

(3) Funds in the account derived from nursing facilities that are not operated by a governmental entity shall not be used to replace other general revenues appropriated and funded by the General Assembly or other revenues used to support Medicaid.

(4) This designated account shall be exempt from budgetary cuts, reductions, or eliminations caused by a deficiency of general revenues.

(5) Earnings on investments from this designated account shall remain a part of the designated account and shall not be deposited into the general fund.

(d)(1) Except as necessary to reimburse any funds borrowed to supplement funds in the designated account, the designated account moneys in the Arkansas Medicaid Program Trust Fund and the matching federal financial participation under Title XIX of the Social Security Act for expenditures from the Arkansas Medicaid Program Trust Fund shall be used only to reimburse additional costs paid to Medicaid-certified nursing facilities under the long-term care cost reimbursement methodologies of the Arkansas Medicaid Program.

(2) No nursing facility shall be guaranteed, expressly or otherwise, that any additional moneys paid to the nursing facility will equal or exceed the amount of its quality assurance fee.

History. Acts 2001, No. 635, § 4.

U.S. Code. Title XIX of the Social

Security Act, referred to in this section, is codified as 42 U.S.C. § 1396 et seq.

20-10-1605. [Repealed.]

Publisher's Notes. This section, concerning billing statements, was repealed

by Acts 2003, No. 746, § 1. The section was derived from Acts 2001, No. 635, § 6.

20-10-1606. Waiver for nursing facilities under life-care facility contracts.

(a) The Department of Human Services shall apply for a waiver of the uniform healthcare-related tax under 42 C.F.R. § 433.68, as in effect on January 1, 2007, to exempt each nursing facility that provides nursing care exclusively under contract with life-care facilities licensed under § 23-93-201 et seq. from the quality assurance fee and to allow adjustment of the quality assurance fee paid by state-operated nursing facilities.

(b) Upon receiving the waiver, the department shall discontinue collecting the quality assurance fee from any nursing facility that provides nursing care exclusively under life-care facility contracts and adjust the quality assurance fee paid by state-operated nursing facilities pursuant to the waiver.

History. Acts 2007, No. 155, § 1.

SUBCHAPTER 17 — ARKANSAS ASSISTED LIVING ACT

SECTION.

- 20-10-1701. Title.
- 20-10-1702. Purpose and intent.
- 20-10-1703. Definitions.
- 20-10-1704. Assisted living program.
- 20-10-1705. Fees.

SECTION.

- 20-10-1706. Reimbursement.
- 20-10-1707. Licensure.
- 20-10-1708. Limited licensure option.
- 20-10-1709. Permit of approval.

Effective Dates. Acts 2001, No. 1230, § 10: Apr. 2, 2001. Emergency clause provided: “It is hereby found and determined by the Eighty-third General Assembly that because of eligibility rules in the state’s Medicaid program many low to moderate income citizens are being prevented from accessing the most appropriate health care setting; that assisted living is being underutilized in Arkansas; that the current paperwork burden in the Medicaid personal care program discourages participation by Medicaid providers; and that until this situation is changed, the citizens will be deprived of access to

appropriate health care. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto.”

20-10-1701. Title.

This subchapter shall be known as the “Arkansas Assisted Living Act”.

History. Acts 2001, No. 1230, § 1.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of assembly, Public Health and Welfare, 24 U. Legislation, 2001 Arkansas General As- Ark. Little Rock L. Rev. 557.

20-10-1702. Purpose and intent.

(a) The purpose of this subchapter is to:

(1) Promote the availability of appropriate services for elderly persons and adults with disabilities in the least restrictive and most homelike environment;

(2) Encourage the development of facilities that promote the dignity, individuality, privacy, and decision-making ability of those persons;

(3) Provide for the health, safety, and welfare of residents of facilities offering assisted living services in the state;

(4) Promote continued improvement of those facilities;

(5) Include residential care facilities in the assisted living program; and

(6) Encourage the development of innovative and affordable facilities particularly for persons with low to moderate incomes.

(b) The General Assembly recognizes that:

(1) Facilities offering assisted living services are a necessary part of the continuum of long-term care in the State of Arkansas;

(2) Facilities offering assisted living services should be operated and regulated as residential environments with supportive services and not as medical or nursing facilities;

(3) The services available in these facilities, either directly or through contract or agreement, are intended to help residents remain as independent as possible; and

(4) Residential care facilities have been providing many assisted living services for years and should be allowed to participate in the new assisted living program.

History. Acts 2001, No. 1230, § 2.

CASE NOTES

Cited: Ark. Residential Assisted Living Comm'n, 364 Ark. 372, 220 S.W.3d 665 Ass'n v. Ark. Health Servs. Permit (2005).

20-10-1703. Definitions.

As used in this subchapter:

(1)(A) "Assisted living facility" means any building or buildings, section or distinct part of a building, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide assisted living services for a period exceeding twenty-four (24) hours to more than three (3) adult residents of the facility who are not relatives of the owner or administrator.

(B) “Assisted living facility” includes those facilities which provide assisted living services either directly or through contractual arrangements or which facilitate contracting in the name of residents;

(2) “Assisted living program” means a program of assisted living services;

(3) “Assisted living services” means housing, meals, laundry, socialization, transportation, one (1) or more personal services, and limited nursing services;

(4) “Department” means the Department of Human Services and its divisions and offices;

(5)(A) “Limited nursing services” means acts that may be performed by licensed personnel while carrying out their professional duties, but limited to those acts that the department specifies by rule.

(B) Acts that may be specified by rule as allowable limited nursing services shall be for persons who meet the admission criteria established by the department for assisted living facilities, shall not be complex enough to require twenty-four-hour nursing supervision, and may include such services as the application and care of routine dressings and care of casts, braces, and splints;

(6) “Person” means an individual, partnership, association, corporation, or other entity;

(7)(A) “Personal services” means assistance with or supervision of the activities of daily living and self-administration of medication and other similar services as the department may define by rule.

(B) “Personal services” shall not be construed to mean the provision of medical, dental, or alcohol and drug abuse treatment or mental health services; and

(8) “Twenty-four-hour nursing” means services that are ordered by a physician for a resident whose condition requires the supervision of a physician and continued monitoring of vital signs and physical status and whose condition is medically complex enough to require on-site nursing supervision on a twenty-four-hour per day basis.

History. Acts 2001, No. 1230, § 3.

CASE NOTES

Assisted Living Facility.

Plaintiff injured party, contending that defendant was an assisted living facility rather than an apartment complex, appended documents to her response to the motion for summary judgment, including a Facebook page describing defendant as a “Retirement & Assisted Living Facility”; the trial court properly held that the postings were of unknown origin and not reli-

able, and there was no proper evidence to rebut the defense witness’s sworn testimony. *Hadder v. Heritage Hill Manor, Inc.*, 2016 Ark. App. 303, 495 S.W.3d 628 (2016).

Cited: *Ark. Residential Assisted Living Ass’n v. Ark. Health Servs. Permit Comm’n*, 364 Ark. 372, 220 S.W.3d 665 (2005).

20-10-1704. Assisted living program.

(a) The Department of Human Services shall establish an assisted living program for adults, including those who meet the medical necessity determination for nursing facility care. However, such individuals cannot have conditions that require twenty-four-hour nursing.

(b)(1) The department shall promulgate rules and regulations not inconsistent with the provisions of this subchapter as it shall deem necessary or desirable to properly and efficiently carry out the purposes and intent of this subchapter.

(2) The regulations, including documentation, shall take into account the congregate nature of assisted living as opposed to individual settings, and the regulations shall include, but not be limited to:

(A) Fire, health, and life safety codes;

(B) Physical plant requirements, including space requirements for housing, toilet facilities, and related items;

(C) Staffing requirements; and

(D) Services requirements.

(c)(1) No resident shall be permitted to remain in an assisted living facility if his or her condition requires twenty-four-hour nursing care or other services that an assisted living facility is not authorized by law to provide.

(2) This prohibition shall apply even if the resident is willing to enter into an agreement to relieve the facility of responsibility or otherwise manage the risk.

(d) Upon application, residential care facilities licensed or holding a permit of approval as of April 2, 2001, and subsequent purchasers shall be licensed as assisted living facilities, provided that:

(1) The facility shall provide a small refrigerator in each resident's room, except as otherwise provided by regulation;

(2) The facility shall provide a microwave oven in each resident's room, except as otherwise provided by regulation;

(3) The facility meets minimum space requirements for resident rooms of one hundred fifty square feet (150 sq. ft.) per person or two hundred thirty square feet (230 sq. ft.) for two (2) persons sharing a room, exclusive of entryway, closet, and bathroom, or one hundred square feet (100 sq. ft.) per person or one hundred eighty square feet (180 sq. ft.) for two (2) persons if the room has a half or full bath or if there is a shared bathroom between two (2) rooms;

(4) The application conforms to all other assisted living regulations, except as provided in this subchapter; and

(5) Before obtaining the assisted living license, the residential care facility has no more than two (2) Class A or Class B violations pursuant to § 20-10-205 within the previous six (6) months.

(e) Residential care facilities which choose to become assisted living facilities under subsection (d) of this section shall not be required to meet physical plant or other physical amenities requirements beyond those required for residential care facilities as of January 1, 2001, except as provided in subsection (d) of this section.

(f) Assisted living regulations promulgated by the department shall be reasonable and shall not have the effect of excluding residential care facilities from entering the program, provided they meet the requirements of this subchapter.

(g)(1) The department shall take all actions necessary to develop a home- and community-based care waiver application in accordance with § 1915(c) of the Social Security Act.

(2) The waiver application shall seek federal financial participation to increase access to services in assisted living facilities by raising Medicaid income and resource limits to the maximum eligibility level of other home- and community-based waivers in effect.

(3) The waiver application shall seek permission to serve a minimum of one thousand (1,000) persons at a time and shall be submitted to the Centers for Medicare & Medicaid Services by June 30, 2001.

(4) The department's implementation of the waiver shall be reasonable and shall not have the effect of excluding residential care facilities which have become assisted living facilities under the provisions of this subchapter.

(h)(1) Residential care facilities that choose not to become assisted living facilities will be permitted to continue participating in the Medicaid personal care program.

(2) If an assisted living facility has Medicaid residents who are not in the waiver program but could qualify for nonwaiver Medicaid services, then the facility shall be permitted to provide Medicaid personal care for those residents.

(i) Assisted living services may be provided directly or through contractual arrangement.

History. Acts 2001, No. 1230, § 4.

U.S. Code. Section 1915(c) of the Social

Security Act, referred to in this section, is codified at 42 U.S.C. § 1396n(c).

CASE NOTES

Cited: Ark. Residential Assisted Living
Ass'n v. Ark. Health Servs. Permit

Comm'n, 364 Ark. 372, 220 S.W.3d 665
(2005).

20-10-1705. Fees.

(a) The Department of Human Services may charge fees which shall be paid by assisted living facilities to cover administrative costs associated with licensing, inspection, and the regulation of assisted living facilities.

(b) The department shall promulgate rules and regulations necessary for charging administrative fees.

History. Acts 2001, No. 1230, § 5.

20-10-1706. Reimbursement.

For Medicaid-eligible clients, the Department of Human Services shall reimburse assisted living facilities on a per diem basis in accordance with approval for per diem reimbursement from the Centers for Medicare & Medicaid Services.

History. Acts 2001, No. 1230, § 6.

20-10-1707. Licensure.

(a)(1) Each assisted living facility in the State of Arkansas shall first obtain a license to operate from the Department of Human Services.

(2) The department shall promulgate rules and regulations for the licensure and operation of assisted living facilities.

(b) Any person establishing, conducting, managing, or operating an assisted living facility within the meaning of this subchapter or using the term “assisted living” to promote the facility’s services without first having obtained an assisted living license shall be guilty of a Class A misdemeanor and upon conviction shall be subject to the penalties prescribed for a Class A misdemeanor. However, residential care facilities licensed or holding a permit of approval as of April 2, 2001, may use the term “assisted living” to promote their services.

(c) Each day that an assisted living facility shall operate after a first conviction shall be considered a Class D felony, and the person establishing, conducting, managing, or operating an assisted living facility upon conviction shall be subject to the penalties prescribed for a Class D felony.

History. Acts 2001, No. 1230, § 7.

CASE NOTES

Cited: Ark. Residential Assisted Living Comm’n, 364 Ark. 372, 220 S.W.3d 665 Ass’n v. Ark. Health Servs. Permit (2005).

20-10-1708. Limited licensure option.

A facility licensed as of April 2, 2001, and subsequent purchasers have the option of converting all or part of the facility to assisted living under § 20-10-1704(d) or choosing to remain licensed as a residential care facility.

History. Acts 2001, No. 1230, § 8.

20-10-1709. Permit of approval.

(a) Facilities offering assisted living services shall obtain a permit of approval. However, permits of approval held by residential care facilities as of April 2, 2001, or held by subsequent purchasers of those facilities, shall also be considered permits of approval for assisted living without further action. However, residential care facilities that choose

to offer assisted living services are not exempted from assisted living licensure requirements except as provided in § 20-10-1704.

(b)(1)(A) Provided, further, that in order to take advantage of a Robert Wood Johnson Foundation grant, one (1) new facility chosen by the Department of Human Services may serve as a pilot project without the necessity of a permit of approval. This facility shall be exempt from the permit of approval process, provided that in 2001 it is awarded funding from the Coming Home Project and tax credits from the Arkansas Development Finance Authority.

(B) The Coming Home Project means the Robert Wood Johnson Foundation/NCB Development Corporation grant.

(2) The facility shall have no more than sixty (60) beds and shall serve a population a majority of which is low-income as defined by the United States Department of Housing and Urban Development.

(3) The pilot project facility shall still meet all other licensure requirements.

History. Acts 2001, No. 1230, § 9.

CASE NOTES

In General.

Arkansas Supreme Court rejected the claim by nursing facility association that permits of approval for residential-care facilities had to be counted as permits of approval for assisted-living facilities; therefore, regulation 500M of the Health Services Permit Commission was not invalid because it did not conflict with this

section, and the decision to issue and abide by regulation 500M was not arbitrary as the commission and the Health Services Permit Agency engaged in significant research and analysis before issuing regulation 500M. *Ark. Residential Assisted Living Ass'n v. Ark. Health Servs. Permit Comm'n*, 364 Ark. 372, 220 S.W.3d 665 (2005).

SUBCHAPTER 18 — LONG-TERM CARE FACILITIES EMERGENCY GENERATOR
ACT OF 2001

SECTION.

20-10-1801. Title.

20-10-1802. Definitions.

SECTION.

20-10-1803. Requirements.

20-10-1804. Penalties.

Effective Dates. Acts 2001, No. 1602, § 2: Apr. 13, 2001. Emergency clause provided: "It is found and determined by the General Assembly that the lack of emergency generator that will power critical nursing facility systems in the event of power outages, interruptions or loss of power, endanger the health, safety and welfare of nursing home residents, who are among the most vulnerable and physically at-risk citizens of the State of Arkansas. Therefore, an emergency is declared

to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

20-10-1801. Title.

This subchapter shall be known and may be cited as the “Long-Term Care Facilities Emergency Generator Act of 2001”.

History. Acts 2001, No. 1602, § 1.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of assembly, Public Health and Welfare, 24 U. Legislation, 2001 Arkansas General As- Ark. Little Rock L. Rev. 557.

20-10-1802. Definitions.

As used in this subchapter:

(1) “Areas of refuge” means any hallways, corridors, dining facilities, lobbies, reception areas, or community rooms designated by the nursing facility and approved by the Office of Long-Term Care;

(2) “Critical systems” means:

(A) Heating systems;

(B) Cooling systems;

(C) Call light or nurse call system;

(D) Illumination, heating and cooling, and life-support equipment or life-sustaining equipment in areas of refuge;

(E) Alarm systems, including fire and smoke alarms and fire extinguishing systems;

(F) Paging systems or speaker systems if intended for communication during an emergency;

(G) Life-sustaining equipment and life-support equipment;

(H) Refrigeration for medications and for food and liquids that require refrigeration;

(I) Continuous operation of telephone systems;

(J) Hot water circulation pumps and boiler rooms; and

(K) Elevators in facilities with elevators;

(3) “Existing facility” means a facility constructed or for which plans for construction have been approved by the Office of Long-Term Care, before April 13, 2001;

(4) “Facility” means a nursing facility or nursing home; and

(5) “New resident” means a person who has not been previously admitted to the nursing facility in the last fourteen (14) days.

History. Acts 2001, No. 1602, § 1.

20-10-1803. Requirements.

(a)(1) No later than six (6) months from April 13, 2001, each nursing facility or nursing home shall submit for approval to the Office of Long-Term Care plans prepared by a licensed architect, engineer, electrician, or individual deemed qualified by the manufacturer of the generator for the installation of an emergency generator sufficient to provide:

(A)(i) For existing facilities, power to critical systems for a period of no less than forty-eight (48) continuous hours in the event of interruption of normal power supplies.

(ii) However, nursing facilities are not required to provide heating or cooling to areas not designated and approved as areas of refuge; and

(B) For facilities constructed after April 13, 2001, power to all systems in the entire nursing facility that require electric power for operation for a period of no less than forty-eight (48) continuous hours in the event of interruption of normal power supplies:

(i) Facilities constructed after April 13, 2001, are not required to provide power to air conditioning systems to residents' rooms; and

(ii) Facilities constructed after April 13, 2001, are required to provide power to air conditioning systems for areas of refuge.

(2) By November 1, 2002, each facility shall either:

(A) Have the emergency generator installed and functioning; or

(B)(i) Have appropriate access for an emergency generator to be installed and functioning and have signed a lease agreement ensuring that the facility will have an approved emergency generator installed and functioning within eight (8) hours of an emergency electrical outage.

(ii) However, facilities shall provide emergency power to life-sustaining equipment and life-support equipment and to exit lighting immediately upon loss of normal or regular power supplies.

(3) If the office determines that a plan does not meet the requirements of this subchapter:

(A) The office shall notify the facility in writing that the plan is unacceptable and shall state the specific deficiencies in the plan; and

(B)(i) The facility shall submit a revised plan to the office within sixty (60) days of the date of the written notice.

(ii) The revised plan shall correct the deficiencies listed in the written notice to the office.

(4)(A) If a facility does not agree with the determination by the office that a plan is unacceptable, the facility may appeal the determination pursuant to § 20-10-303 [repealed].

(B) However, the filing of an appeal shall not stay the requirements under subdivision (a)(2) of this section.

(b)(1) At least one (1) time a year, the facility shall have the system tested by a licensed engineer or other individual deemed qualified by the manufacturer of the generator to ensure that the system will operate as required in the event of loss of normal power.

(2) The facility shall retain a copy of the statement of the qualified professional attesting to the fitness of the system until the next licensure survey by the office.

(c)(1) The facility shall start the emergency generator at least one (1) time each month and shall ensure that the generator remains in proper operating condition.

(2) The facility shall perform all recommended and required maintenance and tests on the emergency system as specified by the manu-

facturer of the system or as recommended by the person or entity performing the installation.

(3) Until the next licensure survey by the office, the facility shall record and maintain a log of all maintenance performed by the facility and of each monthly start-up and the operating condition of the generator at each monthly start-up.

(d) Unless otherwise specified in this subchapter, the installation and maintenance of the generator shall meet the requirements specified in National Fire Protection Association publications.

History. Acts 2001, No. 1602, § 1.

20-10-1804. Penalties.

(a) If a nursing facility or nursing home fails to comply with this subchapter, the following penalties may be applied to the facility:

(1) A fine not to exceed five thousand dollars (\$5,000) may be assessed by the Office of Long-Term Care for each month in which the facility fails to comply with any provision of this subchapter;

(2)(A) A fine not to exceed ten thousand dollars (\$10,000) may be assessed by the office for each calendar day during which a facility lacks electrical power if the outage continues for more than eight (8) consecutive hours.

(B) However, the fine may be imposed if the facility fails to provide emergency power for life-sustaining equipment or life-support equipment and to exit lighting immediately upon loss of normal or regular power supplies;

(3) In addition to any fine or other penalty, the facility may be prohibited from admitting new residents until the facility is in compliance with the requirements of this subchapter, as determined by the office;

(4) A fine not to exceed ten thousand dollars (\$10,000) may be assessed by the office for each new admission that occurs during a period in which new admissions are prohibited;

(5) Appeals from the imposition of any monetary penalty under this subchapter shall be made pursuant to § 20-10-208; and

(6) Appeals from the imposition of a denial of new admissions under this subchapter shall be made pursuant to § 20-10-303 [repealed].

(b) Penalties allowed under this subchapter may be waived by the office for any existing facility that is scheduled to be replaced by a new facility which is under construction as of June 1, 2002.

(c) Penalties under this subchapter shall be waived when the generator is rendered inoperable due to natural disaster or other conditions beyond the control or authority of the facility and when the facility has taken reasonable actions to ensure the operation of the generator.

History. Acts 2001, No. 1602, § 1.

SUBCHAPTER 19 — DISPUTE RESOLUTION FOR LONG-TERM CARE FACILITIES

SECTION.

- 20-10-1901. Purpose.
 20-10-1902. Definitions.
 20-10-1903. Informal dispute resolution hearing.
 20-10-1904. Impartial decision maker — Qualifications.
 20-10-1905. Request for informal dispute resolution.
 20-10-1906. Scheduling informal dispute resolution hearings — Submission of documentary evidence.

SECTION.

- 20-10-1907. Informal dispute resolution hearing — Conduct.
 20-10-1908. Determination of impartial decision maker and Office of Long-Term Care.
 20-10-1909. Matters not subject to informal dispute resolution.
 20-10-1910. Effect of request for informal dispute resolution.

20-10-1901. Purpose.

(a) The General Assembly finds that this subchapter is necessary to provide an alternative process to formal judicial or administrative appeals of deficiencies for long-term care facilities as a means for faster, more efficient, and less expensive resolution of disputes concerning deficiencies cited against long-term care facilities.

(b) It is the intent of the General Assembly to provide a process supplemental to formal appeal that is both fair and impartial to all parties to address disputes between long-term care facilities and the Office of Long-Term Care when a deficiency is cited against a long-term care facility.

History. Acts 2003, No. 1108, § 1.

20-10-1902. Definitions.

As used in this subchapter:

(1) “Deficiency” means a violation or alleged violation by a long-term care facility of applicable state or federal laws, rules, or regulations governing the operation or licensure of a long-term care facility;

(2) “Deficiency tag number” means an alphanumeric designation of a deficiency by the Office of Long-Term Care that denotes the applicable state or federal rule, regulation, or law allegedly violated and that is used on the statement of deficiencies;

(3)(A) “Impartial decision maker” means an individual employed by a state agency to conduct an informal dispute resolution hearing for the agency.

(B) “Impartial decision maker” does not include an individual who is presently or has been within the previous twenty-four (24) months actively involved in any survey process under the Department of Human Services;

(4) “Informal dispute resolution” means a nonjudicial process or forum before an impartial decision maker that provides a long-term care facility cited for deficiency with the opportunity to dispute a citation for deficiency;

(5) “Long-term care facility” has the same meaning as under § 20-10-213;

(6) “Party” means a long-term care facility requesting an informal dispute resolution hearing or the office, or both;

(7) “State survey agency” means the Office of Long-Term Care, which is the federally designated state entity that performs Medicaid and Medicare surveys and inspections of Arkansas long-term care facilities; and

(8)(A) “Statement of deficiencies” means a statement prepared by the office citing the applicable state or federal laws, rules, or regulations violated by a long-term care facility and the facts supporting the citation.

(B) A statement of deficiencies may also be referred to as a “2567”.

History. Acts 2003, No. 1108, § 1; 2011, No. 1144, § 1.

20-10-1903. Informal dispute resolution hearing.

(a) Informal dispute resolution shall be conducted by the Department of Health.

(b) The department shall assign all informal dispute resolution hearings to the unit or section charged with performing survey or inspection activity for hospitals and hospital-based skilled nursing facilities.

History. Acts 2003, No. 1108, § 1.

20-10-1904. Impartial decision maker — Qualifications.

(a) The impartial decision maker may be an individual or a committee of individuals employed by the Department of Health.

(b)(1) An impartial decision maker shall be a nurse, a physician, a pharmacist, or any combination of nurses, physicians, or pharmacists, employed by the department.

(2) Each person acting as an impartial decision maker shall be licensed by the State of Arkansas by their respective licensing agencies or boards.

(c) All impartial decision makers shall undergo and complete surveyor training arranged by the Office of Long-Term Care.

History. Acts 2003, No. 1108, § 1.

20-10-1905. Request for informal dispute resolution.

(a) A long-term care facility that wishes to challenge a deficiency shall make a written request to the Department of Health within ten (10) calendar days of the receipt of the statement of deficiencies from the Office of Long-Term Care.

(b) The written request shall include:

(1) A list of all deficiencies that the long-term care facility wishes to challenge; and

(2) A statement indicating whether the long-term care facility wants the hearing to be conducted by telephone conference call, by record review of the impartial decision maker, or by a meeting in which the long-term care facility and the office appear before the impartial decision maker.

History. Acts 2003, No. 1108, § 1.

20-10-1906. Scheduling informal dispute resolution hearings — Submission of documentary evidence.

(a)(1) Upon receipt of a request for an informal dispute resolution hearing from a long-term care facility, the Department of Health shall assign the matter to an impartial decision maker.

(2) If a deficiency in dispute concerns a pharmacy, a pharmacist, a pharmacy tag, or a deficiency where the expertise of a pharmacist is required, the impartial decision maker shall:

(A) Be a pharmacist if the impartial decision maker is a single individual; or

(B) Include a pharmacist if the impartial decision maker is a group of individuals.

(b) The impartial decision maker shall:

(1) Schedule a time and date for a hearing; and

(2) Inform the parties of the time and date of the hearing.

(c) If the request for an informal dispute resolution hearing includes a request by the long-term care facility for a hearing at which the long-term care facility may appear before the impartial decision maker, the impartial decision maker shall:

(1) Arrange for facilities appropriate for conducting the hearing; and

(2) Inform the parties of the location of the facility.

(d)(1) Each party shall submit to the impartial decision maker all documentary evidence that the party believes has a bearing on or relevance to the deficiencies in dispute by the date specified by the impartial decision maker.

(2) Documentary evidence that is not submitted by the date specified by the impartial decision maker may be:

(A) Refused and not considered by the impartial decision maker; or

(B)(i) Accepted by the impartial decision maker.

(ii) If the evidence is accepted, the impartial decision maker shall provide the opposing party the opportunity to submit additional documentary evidence.

(iii) However, the additional evidence shall be limited to information that addresses or rebuts the documentary evidence submitted after the date specified by the impartial decision maker.

(e)(1) If the request for an informal dispute resolution hearing does not include a request by the long-term care facility for a hearing at which the long-term care facility may appear before the impartial

decision maker, or upon agreement of the long-term care facility and the Office of Long-Term Care, the impartial decision maker may conduct the hearing by telephone conference call or by a review of documentary evidence submitted by the parties.

(2)(A) If the informal dispute resolution hearing is conducted by record review, the impartial decision maker may request, and the parties shall provide, a written statement setting forth the parties' positions for accepting, rejecting, or modifying each deficiency in dispute.

(B) The written statement shall specify the documentary evidence that supports the position of each party for each deficiency in dispute.

(C) The long-term care facility shall provide its written statement to the impartial decision maker and the office.

(D) The office shall then provide its written statement in rebuttal to the impartial decision maker and the long-term care facility.

History. Acts 2003, No. 1108, § 1; 2011, No. 1144, §§ 2, 3.

20-10-1907. Informal dispute resolution hearing — Conduct.

(a) Unless the long-term care facility chooses another order of presentation of arguments:

(1) The Office of Long-Term Care shall present the initial arguments at the hearing; and

(2) After the office completes its arguments, the long-term care facility shall present its arguments.

(b)(1) As a matter of fairness to all parties, the impartial decision maker shall determine in conjunction with all parties:

(A) The appropriate time needed for each presentation of information and argument; and

(B) The sequence and appropriate time for each rebuttal argument.

(2) However, the impartial decision maker may grant each party additional equal time for good cause as determined by the impartial decision maker in conjunction with all parties.

(c)(1) Rules of evidence or procedure shall not apply except as provided in this section.

(2) The impartial decision maker may:

(A) Accept any information that the impartial decision maker deems material to the issue being presented; and

(B) Reject any information that the impartial decision maker deems immaterial to the issue being presented.

(d)(1) The hearing may not be recorded.

(2) However, the impartial decision maker may make written or recorded notes of the arguments.

(e) Only employees of the long-term care facility, attending physicians of residents of the long-term care facility at the time of the deficiency, pharmacists providing medications to residents of the long-

term care facility at the time of the deficiency, and consultant pharmacists or nurse consultants utilized by the long-term care facility or by the medical director of the long-term care facility may appear or participate at the hearing for or on the behalf of the long-term care facility.

(f) Only employees of the office may appear or participate at the hearing for or on behalf of the office.

(g) A person authorized under subsection (e) or subsection (f) of this section to participate in the hearing may present direct questions to an opposing participant during the rebuttal argument.

(h)(1) Within fourteen (14) days of a final decision concerning the issues presented in the hearing and any related matters, the Department of Health shall provide the parties with a report concerning the hearing, all decisions made on the basis of the hearing, and any related matters.

(2) The report required under subdivision (h)(1) of this section shall include without limitation:

(A) Information concerning any change to the disputed deficiency; and

(B) A listing of each specific item of the deficiency and all changes made to the deficiency.

(i)(1) The Department of Human Services shall compile and make available to all long-term care facilities subject to this section a quarterly report that shall include without limitation the number of informal dispute resolutions during the previous quarter that were:

(A) Heard;

(B) Decided in favor of the state agency; and

(C) Decided in favor of the long-term care facility.

(2) The office shall review the reports under subdivision (i)(1) of this section and shall:

(A) Determine what patterns of sustained and overturned deficiencies exist; and

(B) Evaluate the training process to address the identified patterns.

(j) A party shall not be represented by an attorney.

History. Acts 2003, No. 1108, § 1; 2011, No. 1144, § 4.

20-10-1908. Determination of impartial decision maker and Office of Long-Term Care.

(a)(1) Upon the conclusion of all arguments by the parties, the impartial decision maker shall issue a written statement of findings that shall be entitled "Determinations".

(2) The statement shall include:

(A) A recitation of the deficiency tag numbers;

(B) A statement of whether a disputed deficiency should remain, be removed, or be modified on the statement of deficiencies; and

(C) The facts and persuasive arguments that support the impartial decision maker's finding for each deficiency tag number.

(b)(1) The determination of the impartial decision maker shall be provided to the parties.

(2)(A) The Office of Long-Term Care shall review the determination and shall issue a written document entitled "State Survey Agency Determination".

(B) The state survey agency determination shall state:

(i) Whether, for each disputed deficiency mentioned in the impartial decision maker's determination, the finding of the impartial decision maker is accepted, rejected, or accepted as modified by the state survey agency;

(ii) For each deficiency finding by the impartial decision maker that the office does not accept the finding of the impartial decision maker, a statement explaining the reasons that the finding was not accepted along with the facts, circumstances, or reasons for not accepting the finding; and

(iii) For each disputed deficiency finding of the impartial decision maker that the office accepts the finding with modification, a recitation of the modification and the reason or reasons for the modification.

(c) A state survey agency determination is not subject to appeal, reargument, or reconsideration.

(d) The office shall deliver a copy of the state survey agency determination to the long-term care facility and to the impartial decision maker.

(e)(1) In accordance with the state survey agency determination, the office shall issue an amended state of deficiencies if the state survey agency determination results in modification to any deficiencies cited in the original statement of deficiencies.

(2) If the office determines that amendments to the statement of deficiencies should result in changes to the scope or severity assigned to any deficiency, the amended statement of deficiencies shall reflect the changes to the scope or severity of any cited deficiency.

(f) The amended statement of deficiencies shall be provided to the long-term care facility.

History. Acts 2003, No. 1108, § 1.

20-10-1909. Matters not subject to informal dispute resolution.

(a)(1) The informal dispute resolution hearing is limited to deficiencies cited on a statement of deficiencies.

(2) No other issues may be addressed at an informal dispute resolution hearing, including, but not limited to:

(A) Scope and severity assessments of deficiencies unless the scope and severity assessments allege substandard quality of care or immediate jeopardy;

(B) Any remedies imposed;

(C) Any alleged failure of the survey team to comply with a requirement of the survey process;

(D) Any alleged inconsistency of the survey team in citing deficiencies among long-term care facilities; and

(E) Any alleged inadequacy or inaccuracy of the informal dispute resolution process.

(b) If the impartial decision maker finds that matters not subject to informal dispute resolution are presented, the impartial decision maker shall strike all documentary evidence related to or presented for the purpose of disputing the matter not subject to informal dispute resolution.

(c) The impartial decision maker may not include in the determination any matter not subject to informal dispute resolution.

History. Acts 2003, No. 1108, § 1.

20-10-1910. Effect of request for informal dispute resolution.

A request for an informal dispute resolution shall not:

(1) Stay any action for enforcement or imposition of remedies; or

(2) Affect or preclude a facility’s right to judicial or administrative appeal.

History. Acts 2003, No. 1108, § 1.

SUBCHAPTER 20 — UNLICENSED LONG-TERM CARE FACILITIES ACT

SECTION.

20-10-2001. Title.

20-10-2002. Purpose.

20-10-2003. Definitions.

20-10-2004. Licensure.

SECTION.

20-10-2005. Existing unlicensed facilities.

20-10-2006. Application.

20-10-2007. Penalties and enforcement.

Effective Dates. Acts 2005, No. 2191, § 11: Apr. 13, 2005. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that various long-term care facilities are operating in this state without having obtained a license; that there is no state oversight or protection for the vulnerable residents in these facilities; and that there is no way of ensuring that the facilities properly treat and protect these residents under state long-term care laws.

Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

20-10-2001. Title.

This subchapter shall be known and may be cited as the “Unlicensed Long-Term Care Facilities Act”.

History. Acts 2005, No. 2191, § 10.

20-10-2002. Purpose.

The purpose of this subchapter is to protect the elderly and other vulnerable citizens of the State of Arkansas by ensuring that all facilities that offer assisted living or similar services are properly licensed and following the statutes and rules for long-term care facilities.

History. Acts 2005, No. 2191, § 10.

20-10-2003. Definitions.

As used in this subchapter:

- (1) "Assisted living facility" means the same as in § 20-10-1703;
- (2) "Congregate services" means provision of group meals or any activities of daily living and instrumental activities of daily living provided in a group setting;
- (3) "Department" means the Department of Human Services and its divisions and offices;
- (4) "Person" means an individual, partnership, association, corporation, or other entity;
- (5) "Residential care facility" means the same as in § 20-10-101; and
- (6) "Supervision" means that an assisted living facility or a residential care facility monitors the condition or status of the resident as related to medical or personal care while in the facility.

History. Acts 2005, No. 2191, § 10.

20-10-2004. Licensure.

(a) Any assisted living facility or residential care facility composed of a building or buildings, section, or distinct part of a building, whether operated for profit or not, shall be licensed as a long-term care facility by the Office of Long-Term Care if the facility:

- (1) Houses more than three (3) individuals for a period exceeding twenty-four (24) hours;
- (2) Provides meals or other congregate services; and
- (3) Either:
 - (A) Provides supervision of residents; or
 - (B) Offers or provides assistance with activities of daily living, including, but not limited to:
 - (i) Eating;
 - (ii) Bathing;
 - (iii) Dressing;
 - (iv) Grooming;
 - (v) Ambulating;
 - (vi) Toileting; or
 - (vii) Taking medications.

(b) Facilities subject to the licensure requirement in subsection (a) of this section include those which:

(1) Provide services either directly or through contractual arrangements; or

(2)(A) Facilitate contracting in the name of the residents.

(B) Apartment house managers referring residents to home health or other service agencies are not facilitating contracting within the meaning of this subdivision (b)(2).

(c) No facility may advertise or publicly represent that it provides assisted living or residential care or use other similar terms unless it is licensed under Arkansas law as an assisted living facility or residential care facility.

History. Acts 2005, No. 2191, § 10.

20-10-2005. Existing unlicensed facilities.

(a) Assisted living facilities and residential care facilities that are unlicensed on April 13, 2005, shall have until March 15, 2006, in which to apply for an assisted living facility license or residential care facility license.

(b) Any assisted living facility or residential care facility that fails to become licensed on or before October 15, 2007, shall be subject to the provisions of § 20-10-2007.

(c)(1) An assisted living facility or residential care facility shall be exempt from the state permit-of-approval process for purposes of this section if the facility obtains a license within the time provided in subsection (b) of this section.

(2) After the time provided in subsection (b) of this section, the facility shall comply with the permit-of-approval process and methodology in all other respects.

(d) The Office of Long-Term Care shall report to the Health Services Permit Agency when a facility has been licensed without a state permit of approval under this section.

(e) The agency shall take account of the new beds in its counting for need purposes under the permit-of-approval methodology.

History. Acts 2005, No. 2191, § 10.

20-10-2006. Application.

(a) This subchapter shall not apply to situations in which persons in independent apartments receive home health services as with the Meals on Wheels program or other services by agencies such as the area agencies on aging but in which:

(1) Congregate services are not offered; and

(2) The situation is not advertised or publicly represented as assisted living, residential care, or a similar type of facility.

(b) As used in this section, "congregate services" does not include:

(1) Coordinating dining and social activities with a separately owned nonprofit senior citizen’s center; or

(2) Arrangements of other types between area agencies on aging and government-subsidized housing projects existing on April 13, 2005.

History. Acts 2005, No. 2191, § 10.

20-10-2007. Penalties and enforcement.

(a) Each person establishing, conducting, managing, constructing, or operating an assisted living facility or residential care facility without a license in violation of this subchapter or using the terms “assisted living”, “residential care”, or similar term to promote the facility’s services without first having obtained a license is subject to penalties under this chapter for operating an unlicensed long-term care facility.

(b) The Department of Human Services shall have the same powers to enforce this subchapter as are authorized in § 20-10-215.

(c)(1) The department may enter and inspect suspected unlicensed assisted living or residential care facilities, including any combination of separate entities working in concert within the meaning of § 20-10-215 without first having secured a warrant.

(2) If a facility denies or refuses the department entry or denies, refuses, or interferes with inspection by the department, the department may apply for and shall be granted an injunction in the name of the state to prohibit the facility from operating until the department is permitted to enter and inspect the facility.

History. Acts 2005, No. 2191, § 10.

SUBCHAPTER 21 — ARKANSAS OPTIONS COUNSELING FOR LONG-TERM CARE PROGRAM

SECTION.	SECTION.
20-10-2101. Definitions.	20-10-2104. Eligibility.
20-10-2102. Admissions.	20-10-2105. Consultations — Timing —
20-10-2103. Arkansas Options Counseling for Long-Term Care Program — Creation — Administration.	Content — Reporting.
	20-10-2106. Rules.
	20-10-2107. Fees.

20-10-2101. Definitions.

As used in this subchapter:

(1) “Long-term care facility” means a nursing facility or a licensed level II assisted living facility;

(2) “Medicaid” means the medical assistance program established under § 20-77-101 et seq.;

(3) “Nursing facility” has the same meaning as in § 20-10-1401;

(4) “Options counseling for long-term care” means the process of providing service under the Arkansas Options Counseling for Long-Term Care Program; and

(5) “Representative” means a family member, attorney, hospital social worker, or any other person chosen by an individual to act on behalf of the individual:

(A) Seeking a long-term care consultation; or

(B) Admitted to a long-term care facility January 1, 2008, or later.

History. Acts 2007, No. 516, § 1.

20-10-2102. Admissions.

(a) A long-term care facility shall notify the Office of Long-Term Care no later than the next business day of all admissions.

(b) Notification shall be made in the manner prescribed by the office.

History. Acts 2007, No. 516, § 1.

20-10-2103. Arkansas Options Counseling for Long-Term Care Program — Creation — Administration.

(a) The Arkansas Options Counseling for Long-Term Care Program is created within the Department of Human Services.

(b) The program shall provide individuals or their representatives, or both, with long-term care consultations that shall include information about, at a minimum:

(1) Long-term care options and costs;

(2) An assessment of an individual’s functional capabilities; and

(3) The conducting of all or part of a professional review, assessment, and determination of appropriate long-term care options.

(c) The program shall be administered by the department.

History. Acts 2007, No. 516, § 1.

20-10-2104. Eligibility.

Each individual in the following categories may be provided with an options counseling for long-term care consultation:

(1) An individual admitted to a long-term care facility regardless of payment source;

(2) A long-term care facility resident who applies for Medicaid; and

(3) An individual who requests a long-term care consultation.

History. Acts 2007, No. 516, § 1.

20-10-2105. Consultations — Timing — Content — Reporting.

(a) An options counseling for long-term care consultation required under this subchapter may be provided at any time, including either before or after the individual who is the subject of a long-term care consultation has been admitted to a long-term care facility.

(b) The information provided through a long-term care consultation under this subchapter shall address all of the following:

(1) The availability of long-term care options that are open to the individual;

(2) Sources and methods of both public and private payment for long-term care services;

(3) Factors to consider when choosing among the available programs, services, and benefits; and

(4) Opportunities and methods for maximizing the independence and self-reliance of the individual, including support services provided by the individual's family, friends, and community.

(c) An individual's long-term care consultation may include an assessment of the individual's functional capabilities and may be provided concurrently with any assessment required by the Department of Human Services.

(d)(1) At the conclusion of an individual's long-term care consultation, the department shall provide the individual or the individual's representative with a summary of options and resources available to meet the individual's needs.

(2) Even though the summary may specify that a source of long-term care other than care in a long-term care facility is appropriate and available, the individual is not required to seek an alternative source of long-term care and may be admitted to or continue to reside in a long-term care facility.

History. Acts 2007, No. 516, § 1.

20-10-2106. Rules.

The Director of the Department of Human Services shall adopt rules necessary to implement and administer this subchapter, including without limitation:

(1) Procedures for a long-term care facility to notify the Office of Long-Term Care of admissions; and

(2)(A) Procedures by which a person in a long-term care facility may decline options counseling for long-term care.

(B)(i) These procedures shall include a form promulgated by the Department of Human Services for use by a long-term care facility.

(ii) The form shall be limited to one (1) page and shall:

(a) Be orally read to the resident or, if applicable, the resident's representative by long-term care facility staff except as provided in this subdivision (2)(B)(ii);

(b) List the date;

(c) State the name of the resident or, if applicable, the resident's representative;

(d) Contain checkboxes indicating that:

(1) The office was notified of the admission;

(2) The form was not read orally to the resident or resident's representative because the resident lacks decisional capacity and does not have a representative; and

(3) The resident or the resident's representative declined the options counseling for long-term care;

(e) Contain a statement and an acknowledgment that options counseling for long-term care is an optional program and may be declined by execution of the form;

(f) Be signed by the resident or, if applicable, the resident's representative; and

(g) Be retained by the long-term care facility in the resident's admission file for eighteen (18) months or until the next standard survey, whichever is longer.

History. Acts 2007, No. 516, § 1; 2009, No. 952, § 2.

20-10-2107. Fees.

(a) After the first three (3) failures of a long-term care facility to complete the form required under § 20-10-2106 in any calendar year, the Department of Human Services shall assess a fee against the long-term care facility of twenty-five dollars (\$25.00) for each failure beyond three (3), with an annual maximum fee of one thousand two hundred dollars (\$1,200).

(b) A long-term care facility assessed a fee under this section may appeal the assessment under § 20-10-208.

History. Acts 2007, No. 516, § 1.

SUBCHAPTER 22 — LONG-TERM CARE QUALITY ASSURANCE

SECTION.

20-10-2201. Purpose — Findings.

20-10-2202. Applicability — Scope.

20-10-2203. Liability of quality assurance committee members — Construction.

SECTION.

20-10-2204. Proceedings and records confidential.

20-10-2205. Duty to advise quality assurance committees.

20-10-2201. Purpose — Findings.

(a) The purpose of the quality assurance committee in a long-term care facility is to evaluate and improve the quality of health care rendered to residents of the facility.

(b) The General Assembly finds that:

(1) Confidentiality of committee proceedings and records is key to improving the quality of care in long-term care facilities by promoting thorough and candid discussions for a full review and analysis of care processes; and

(2) The work of the quality assurance committee is an ongoing process in which individuals from various disciplines meet as a committee to:

(A) Ensure that current practice standards are maintained;

(B) Prevent deviations from care practices to the extent possible;

- (C) Track, trend, and identify care concerns; and
- (D) Correct inappropriate care processes.

History. Acts 2009, No. 198, § 1.

20-10-2202. Applicability — Scope.

(a) This subchapter applies to long-term care facilities as those entities are defined in § 20-10-101.

(b) This subchapter does not expand, limit, or constrict any other privilege, particularly a privilege under § 16-46-105, § 20-9-502, or § 20-9-503.

History. Acts 2009, No. 198, § 1.

20-10-2203. Liability of quality assurance committee members — Construction.

(a) A cause of action for damages or monetary liability shall not arise against a member of the quality assurance committee for an act or proceeding undertaken or performed within the scope of the functions of the quality assurance committee if the committee member acts without malice or fraud.

(b) This subchapter does not confer immunity from liability on an individual while performing services other than as a member of a quality assurance committee.

History. Acts 2009, No. 198, § 1.

20-10-2204. Proceedings and records confidential.

(a)(1) A long-term care facility may appoint members to serve as a duly appointed quality assurance committee in which individuals from various disciplines meet as a committee to:

- (A) Ensure that current practice standards are maintained;
- (B) Prevent deviations from care practices to the extent possible;
- (C) Track, trend, and identify care concerns; and
- (D) Correct inappropriate care processes.

(2)(A) The proceedings of and records that are created by or for the quality assurance committee of a long-term care facility are not subject to discovery or introduction into evidence in a civil action against a provider of professional health services arising out of the matters that are subject to evaluation and review by the quality assurance committee.

(B) Appointments to the quality assurance committee and the dates of the meetings shall be documented and maintained.

(3)(A) A long-term care facility may retain a professional consultant to assist the quality assurance committee in studying quality-of-care concerns.

(B) Any oral or written reports of the consultants to the quality assurance committee are privileged and not subject to discovery or

introduction into evidence in a civil action against a provider of professional health services.

(C) Oral or written communications privileged under this section may be used by the consultant without waiver of the privilege.

(4) A person who was in attendance at a meeting of the quality assurance committee shall not be permitted or required to testify in a civil action as to the following:

(A) Evidence or other matters produced or presented during the proceedings of the quality assurance committee; or

(B) Findings, recommendations, evaluations, opinions, or other actions of the quality assurance committee or any members of the quality assurance committee made or taken in the quality assurance role.

(b)(1) This section does not apply to or affect the discovery or admissibility into evidence in a civil proceeding of the following records:

(A) Records or reports made in the regular course of business by a long-term care facility or other healthcare provider that are not created by or for the quality assurance committee;

(B) Records or reports otherwise available from original sources, including without limitation the medical record of specific residents;

(C) Records or reports required to be kept by applicable law or regulation that are not created by or for the quality assurance committee;

(D) Incident and accident reports;

(E) The long-term care facility's operating budgets; or

(F) Records of the quality assurance committee's meeting dates.

(2) Without waiving any privilege, appointments to the quality assurance committee are available to the Attorney General's Medicaid Fraud Control Unit.

(3) A person who testifies before the quality assurance committee or who is a member of the quality assurance committee shall not be prevented from testifying as to matters within his or her knowledge, but the witness shall not be asked about his or her testimony before the quality assurance committee or about opinions formed by him or her as a result of the committee hearings.

History. Acts 2009, No. 198, § 1.

CASE NOTES

Certiorari.

Petition for a writ of certiorari was not granted in two malpractice cases because it was sought as a remedy for an alleged error in a discovery order relating to a subpoena duces tecum, despite the claim

of privilege under subdivision (a)(2)(A) of this section, 42 U.S.C. § 1320c-9(a), and 42 U.S.C. § 1396r(b)(1)(B). An appeal provided an adequate remedy. *Ark. Found. v. Santarsiero*, 2012 Ark. 372, 423 S.W.3d 542 (2012).

20-10-2205. Duty to advise quality assurance committees.

Upon a request of a quality assurance committee reviewing care provided in a long-term care facility, a physician, administrator, nurse, certified nurse's aide, nurse's aide-in-training, or other individual engaged in work in or about the long-term care facility and having information or knowledge relating to the care provided in the long-term care facility shall advise the quality assurance committee concerning all the relevant facts or information possessed by the individual concerning the quality of care provided in the long-term care facility.

History. Acts 2009, No. 198, § 1.

SUBCHAPTER 23 — PERSONAL CARE SERVICE PROVIDERS**SECTION.**

20-10-2301. Purpose and intent.

20-10-2302. Definitions.

20-10-2303. Private care agencies eligible
for Medicaid reimbursement.

SECTION.

20-10-2304. Rules and regulations.

20-10-2301. Purpose and intent.

(a) The General Assembly recognizes that in order to provide for appropriate health care for all Arkansans:

(1) Personal care service providers are a vital component in the recovery from an illness or an injury;

(2) Sufficient personal care service providers should be available to meet the needs of all eligible recipients; and

(3) Personal care service providers should be allowed to provide in-home personal care service to eligible recipients twenty-four (24) hours a day and seven (7) days a week.

(b) It is the purpose of this subchapter to:

(1) Allow a private care agency to provide in-home personal care services twenty-four (24) hours a day and seven (7) days a week to eligible recipients;

(2) Provide for the reimbursement of the personal care services through Medicaid; and

(3) Authorize the Department of Human Services in its administration of the Arkansas Medicaid Program to set forth Medicaid provider participation requirements for a private care agency that will ensure sufficient available personal care service providers in order to meet the needs of all eligible recipients, including available in-home personal care services twenty-four (24) hours a day and seven (7) days a week.

(c) This subchapter does not supersede department rules that establish monthly benefit limits and prior authorization requirements.

(d) The department is not required to reimburse a private care agency for twenty-four-hour-a-day and seven-day-a-week personal care services.

History. Acts 2009, No. 5, § 1.

20-10-2302. Definitions.

As used in this subchapter, “private care agency” means a provider that is certified by the Division of Aging, Adult, and Behavioral Health Services of the Department of Human Services as a provider of home- and community-based health services and that:

(1) Furnishes in-home staffing services for personal and attendant care services; and

(2) Retains liability insurance of not less than one million dollars (\$1,000,000) to cover its employees and independent contractors while its employees and independent contractors are engaged in providing personal and attendant care services.

History. Acts 2009, No. 5, § 1; 2017, No. 591, § 2.

Amendments. The 2017 amendment substituted “certified by the Division of Aging, Adult, and Behavioral Health Services of the Department of Human Services as a provider of home- and community-based health services” for “licensed

by the Department of Labor and certified as an ElderChoices provider” in the introductory language; and substituted “and attendant care services” for “care services that include without limitation respite services, chore services, and homemaker services” in (1) and (2).

20-10-2303. Private care agencies eligible for Medicaid reimbursement.

The Division of Medical Services of the Department of Human Services shall take such action as required by the Centers for Medicare & Medicaid Services to amend the Arkansas Medicaid Manual to include private care agencies that provide personal care services twenty-four (24) hours a day and seven (7) days a week as a qualified healthcare provider that is eligible for Medicaid reimbursement.

History. Acts 2009, No. 5, § 1.

20-10-2304. Rules and regulations.

(a) The State Board of Health shall promulgate rules necessary to implement this subchapter.

(b) To be eligible for reimbursement under this subchapter, the private care agency shall provide personal care services that comply with rules promulgated by the board.

(c) The board shall establish a separate licensure category for private care agencies that provide personal care services twenty-four (24) hours a day and seven (7) days a week.

(d) The Department of Health shall implement the board’s rules and supervise the conduct of the private care agencies as defined under this subchapter.

History. Acts 2009, No. 5, § 1.

CHAPTER 11

ARKANSAS TUBERCULOSIS SANATORIUM. [REPEALED.]

Publisher's Notes. This chapter, concerning the Arkansas Tuberculosis Sanatorium, was repealed by Acts 2001, No. 1553, § 31. The chapter was derived from the following sections:

20-11-101. Acts 1909, No. 378, § 11, p. 1070; 1911, No. 433, §§ 3, 8; C. & M. Dig., §§ 9632, 9633; Pope's Dig., §§ 12613, 12621, 12622; A.S.A. 1947, §§ 7-312 — 7-314.

20-11-201. Acts 1909, No. 378, § 1, p. 1070; C. & M. Dig., § 9619; Pope's Dig., § 12607; A.S.A. 1947, § 7-301.

20-11-202. Acts 1909, No. 378, § 9, p. 1070; C. & M. Dig., § 9626; Pope's Dig., § 12615; A.S.A. 1947, § 7-307.

20-11-203. Acts 1909, No. 378, § 8, p. 1070; C. & M. Dig., § 9624; Pope's Dig., § 12612; Acts 1955, No. 177, § 1; A.S.A. 1947, § 7-306.

20-11-204. Acts 1939, No. 322, § 1; 1955, No. 177, § 2; A.S.A. 1947, § 7-316.

20-11-301. Acts 1909, No. 378, §§ 10, 11, p. 1070; 1911, No. 433, § 4; C. & M. Dig., §§ 9627, 9628, 9633; Pope's Dig., §§ 12616, 12617, 12622; Acts 1963, No. 271, § 2; A.S.A. 1947, §§ 7-308, 7-314.

20-11-302. Acts 1971, No. 51, § 1; A.S.A. 1947, § 7-332.

20-11-303. Acts 1961, No. 227, §§ 1-3; A.S.A. 1947, §§ 7-329 — 7-331.

20-11-304. Acts 1943, No. 158, §§ 2, 3; 1951, No. 146, § 1; A.S.A. 1947, §§ 7-325 — 7-327.

20-11-305. Acts 1959, No. 85, § 1; A.S.A. 1947, § 7-328.

20-11-401. Acts 1939, No. 322, § 2; A.S.A. 1947, § 7-317.

20-11-402. Acts 1913, No. 199, §§ 4, 5; C. & M. Dig., § 9625; Pope's Dig., § 12614; A.S.A. 1947, §§ 7-318, 7-318n.

20-11-403. Acts 1927, No. 14, §§ 1-6; Pope's Dig., §§ 12624-12629; A.S.A. 1947, §§ 7-319 — 7-324.

CHAPTER 12

RURAL MEDICAL SERVICES

SUBCHAPTER.

1. GENERAL PROVISIONS. [RESERVED.]
2. RURAL MEDICAL CLINIC LOANS.
3. FINANCIAL ASSISTANCE GRANTS. [REPEALED.]
4. RURAL HEALTH SERVICES REVOLVING FUND ACT.
5. PHYSICIAN RECRUITMENT AND RETENTION PROGRAM.
6. REPAYMENT OF FACULTY MEDICAL STUDENT LOANS.

SUBCHAPTER 1 — GENERAL PROVISIONS

[Reserved.]

SUBCHAPTER 2 — RURAL MEDICAL CLINIC LOANS

SECTION.

- 20-12-201. Purpose.
20-12-202. Definitions.

SECTION.

- 20-12-203. Administration.

Effective Dates. Acts 1979, No. 1093,
§ 5: July 1, 1979.

20-12-201. Purpose.

(a) The General Assembly is cognizant of an extreme shortage in the rural areas of this state of obstetricians, gynecologists, general pediatricians, general internists, and family practice physicians.

(b)(1) The providing of incentives to attract and encourage obstetricians, gynecologists, general pediatricians, general internists, and family practice physicians to establish their practices within a rural area of this state is essential to the protection of the public health, welfare, and safety of the people of this state.

(2) By providing a source of low-interest funds, the State of Arkansas can offer incentives to obstetricians, gynecologists, general pediatricians, general internists, and family practice physicians to establish medical clinics in rural areas to meet the medical needs of thousands of citizens of this state.

(c) The procedures set forth in this subchapter to provide loans to these medical practitioners in rural areas for the establishment of medical clinics are deemed to be in the public interest and essential to the preservation of the public health and safety in rural areas.

History. Acts 1979, No. 1093, § 3; A.S.A. 1947, § 82-4301; Acts 1993, No. 762, § 1.

20-12-202. Definitions.

As used in this subchapter:

(1) “Board” means the State Board of Finance;

(2) “Fund” means the Rural Medical Clinic Revolving Loan Fund;

(3) “Rural area” means any city, town, or other area having a population of fifteen thousand (15,000) inhabitants or less according to the 1990 Federal Decennial Census. The census from federal or state penal institutions, federal or state human service institutions, institutions of higher education, or any similar facility shall not be included in the census figure when defining a city, town, or other area under this subchapter; and

(4) “Rural medical clinic loans” means loans in sums not to exceed one hundred fifty thousand dollars (\$150,000) in the aggregate, to be used exclusively for land acquisition or for the construction, reconstruction, repair, or expansion of a building to be used as a medical clinic in a rural area and the acquisition and installation of equipment therein.

History. Acts 1979, No. 1093, § 1; A.S.A. 1947, § 82-4302; Acts 1993, No. 762, § 2; 1995, No. 1088, § 1.

20-12-203. Administration.

(a)(1) There is established on the books of the Treasurer of State, the Chief Fiscal Officer of the State, and the Auditor of State, a fund to be known as the “Rural Medical Clinic Revolving Loan Fund”, which shall

consist of moneys provided by law to be used solely and exclusively for the making of loans by the State Board of Finance, upon application therefor, for the construction and equipping of rural medical clinics in rural areas of this state.

(2) Loans for any one (1) medical practitioner or for the same rural medical clinic shall not exceed in the aggregate the sum of one hundred fifty thousand dollars (\$150,000).

(3) Loans shall be at five percent (5%) interest annually and shall not be for a period of more than ten (10) years.

(b) Before the loan may be made, the State Board of Finance shall determine:

(1) That the rural community in which the rural medical clinic is to be established through a loan made under this subchapter does not have adequate medical services available in the rural community;

(2) That the land, building, and equipment to be acquired, constructed, or renovated through the use of the loan funds are needed to meet the medical needs of the community in which it is to be established;

(3) That the medical practitioners seeking the loan have entered into an agreement with the State Board of Finance, which shall be a part of the loan application and agreement, if approved, to engage in medical practice in the rural medical clinic for the period for which the loan is applied; and

(4) That, if there are not adequate funds available to make loans for rural medical clinics applying for the loans, the State Board of Finance shall make the loans to those rural medical clinics which, in the opinion of the State Board of Finance, will meet the more critical rural medical needs of this state.

(c) Loans made under this subchapter shall be secured by a first lien mortgage on the lands and buildings to be acquired, constructed, or improved and upon the equipment to be installed therein to be used as a medical clinic in the rural area of this state.

(d) If any person obtaining a loan under this subchapter shall be delinquent in making two (2) payments due under the terms of the loan or shall cease to use the property or equipment for which the loan was provided as a medical clinic, the entire unpaid balance of the loan and all unpaid interest thereon shall be due and payable upon a determination of the facts by a court of competent jurisdiction.

(e) The State Board of Finance may make such reasonable rules and regulations and prescribe such forms and procedures as are deemed appropriate to enable it to enforce this subchapter.

(f) In addition to such criteria as are established by the State Board of Finance, the State Board of Health may establish through rules and regulations promulgated by the Department of Health criteria to implement the following requirements:

(1) That a person with an already established practice will not be considered an eligible applicant except under extreme circumstances threatening the continuance of his or her service to the rural community;

(2) That the applicant shall serve a proportionate amount of Medicaid patients for the rural community;

(3) That the applicant shall demonstrate a willingness to work within the existing healthcare system;

(4) That the applicant shall practice a minimum of thirty-two (32) hours a week; and

(5) That no applicant with professional income guarantees from other sources shall be approved under this program.

(g) The department shall develop criteria for evaluating medically underserved areas, which shall include, but not be limited to:

(1) Infant mortality rate;

(2) Poverty population percentage;

(3) Population-to-primary-care-physician ratio; and

(4) Teenage pregnancy rate.

History. Acts 1979, No. 1093, § 2; A.S.A. 1947, § 82-4303; Acts 1993, No. 762, § 3; 1995, No. 1088, § 2.

SUBCHAPTER 3 — FINANCIAL ASSISTANCE GRANTS

SECTION.

20-12-301 — 20-12-303. [Repealed.]

20-12-301 — 20-12-303. [Repealed.]

Publisher's Notes. This subchapter, concerning financial assistance grants, was repealed by Acts 1993, No. 762, § 4. The subchapter was derived from the following sources:

20-12-301. Acts 1979, No. 1094, § 1; A.S.A. 1947, § 82-4304.

20-12-302. Acts 1979, No. 1094, § 2; A.S.A. 1947, § 82-4305.

20-12-303. Acts 1979, No. 1094, § 3; A.S.A. 1947, § 82-4306.

SUBCHAPTER 4 — RURAL HEALTH SERVICES REVOLVING FUND ACT

SECTION.

20-12-401. Title.

20-12-402. Duties.

SECTION.

20-12-403. Creation.

20-12-404. Matching.

Effective Dates. Acts 1989 (1st Ex. Sess.), No. 73, § 10: July 1, 1989. Emergency clause provided: "It is hereby found and determined by the Seventy-Seventh General Assembly that the Rural Health Services are in dire need of matching funds so as not to work irreparable harm upon the proper administration of these services. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health, and safety

shall be in full force and effect from and after July 1, 1989."

Acts 1999, No. 590, § 5: Mar. 15, 1999. Emergency clause provided: "It is hereby found and determined by the Eighty-second General Assembly that there is a pressing and immediate need for financial support in rural areas of Arkansas, that this act has as its purpose the furnishing of financial assistance to rural communities. Therefore, an emergency is declared to exist and this act being immediately

necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the

period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

20-12-401. Title.

This subchapter shall be known as the "Rural Health Services Revolving Fund Act".

History. Acts 1989 (1st Ex. Sess.), No. 73, § 1.

20-12-402. Duties.

(a) It shall be the responsibility of the Department of Health to promulgate all rules and regulations for making application for the matching funds required by this subchapter.

(b) It shall be further the responsibility of the department to review all applications and approve those that shall be eligible for moneys under the provisions of this subchapter and as may otherwise be provided by law.

History. Acts 1989 (1st Ex. Sess.), No. 73, § 2.

20-12-403. Creation.

There is established on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State, a fund to be known as the "Rural Health Services Revolving Fund".

History. Acts 1989 (1st Ex. Sess.), No. 73, § 3.

Cross References. Rural Health Services Revolving Fund, § 19-5-1039.

20-12-404. Matching.

(a)(1) Funds requested by authority of this subchapter shall be matched on a cash basis of fifty to fifty (50:50) by the applicant.

(2) Applicants who have completed a community health needs assessment shall be eligible to match funds requested by authority of this subchapter on a cash basis of twenty-five to seventy-five (25:75) by the applicant.

(b) The state portion shall at no time exceed two hundred thousand dollars (\$200,000) per county, local, commercial, or nonprofit operation.

(c) This match requirement does not apply to funds used by the Department of Health to administer the Rural Health Services Revolving Fund.

History. Acts 1989 (1st Ex. Sess.), No. 73, § 6; 1999, No. 590, § 1.

SUBCHAPTER 5 — PHYSICIAN RECRUITMENT AND RETENTION PROGRAM

SECTION.

20-12-501. Purpose — Grant established.
20-12-502. Administration by the Department of Health.

SECTION.

20-12-503. Eligibility.

Effective Dates. Acts 1991, No. 360, § 7; Mar. 5, 1991. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that many rural communities of the State are in dire need of physicians to supply adequate health care services, that many rural communities are having difficulty recruiting and retaining physicians to practice in their community, that financial incentive is necessary to help physicians locate in rural communities, and that enactment of this legislation will help provide incentive to physicians to locate in the rural communities of this State. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the preservation of the public peace, health and safety, shall take effect and be in force from the date of its approval."

Acts 1999, No. 589, § 7; Mar. 15, 1999. Emergency clause provided: "It is hereby

found and determined by the Eighty-second General Assembly that there is a pressing and immediate need for additional physicians in medically underserved rural areas in Arkansas; and this act has as its purpose the furnishing of financial assistance to physicians who have an interest and desire to engage in rural community practice in Arkansas and will so obligate themselves. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

20-12-501. Purpose — Grant established.

(a) It is the purpose and intent of this subchapter to establish a program of financial assistance to encourage physicians to locate in and remain in the practice of primary care medicine in communities of the state that have a population of not more than fifteen thousand (15,000) persons. It is the intent of the General Assembly that physicians who locate for a minimum of four (4) years in and carry on a full-time practice of family medicine in a priority medically underserved area as defined by the Division of Health Facilities Services of the Department of Health after July 1, 1999, shall be entitled to receive grants totalling fifty-five thousand dollars (\$55,000) to be paid out over four (4) years. The first payment of twenty-five thousand dollars (\$25,000) shall be made when a practice is established by the physician in the community and patients are being seen in the office. The second, third, and fourth payments of ten thousand dollars (\$10,000) each shall be made after completion of each continuous year of service.

(b) It is further the intent of this subchapter that individuals who were assisted by the Arkansas Rural Medical Practice Student Loan and Scholarship Program or the Community Match Loan and Rural Physician Recruitment Program are also eligible for benefits under this program.

History. Acts 1991, No. 360, § 1; 1993, No. 763, § 1; 1995, No. 1089, § 1; 1999, No. 589, § 1. program has been changed to “Community Match Rural Physician Recruitment Program”.

A.C.R.C. Notes. Name of the grant

20-12-502. Administration by the Department of Health.

The program established in this subchapter shall be administered by the Department of Health. The department shall:

- (1) Accept applications for grants under this subchapter;
- (2) Determine the eligibility of applicants and grant or deny such grants from any funds available;
- (3) Adopt and enforce appropriate rules and regulations regarding forms to be used by applicants for grants, and eligibility of applicants, and such other rules and regulations as the department deems necessary or appropriate to carry out the purposes and intent of this subchapter and to prevent abuse of the program provided for in this subchapter; and
- (4) Develop criteria for evaluating medically underserved areas, which shall include, but not be limited to:
 - (A) Infant mortality rate;
 - (B) Poverty population percentage;
 - (C) Population-to-primary-care-physician ratio; and
 - (D) Teenage pregnancy rate.

History. Acts 1991, No. 360, § 3; 1993, No. 763, § 3; 1995, No. 1089, § 2.

20-12-503. Eligibility.

(a)(1) Any person licensed to practice medicine in this state who subsequent to July 1, 1999, establishes a full-time practice of family medicine in a community in Arkansas having a population of not more than fifteen thousand (15,000) persons as set forth in § 20-12-501, when that community is identified by the Department of Health as medically underserved shall be eligible to make application for a grant under this subchapter in an amount described under § 20-12-501.

(2) Grants shall be awarded on the basis of available funds, with priority given to rural communities having the greatest need.

(3) Grant recipients shall enter into a contract to serve a proportionate number of Medicaid patients for the community, agree to work within the existing healthcare system, and practice a minimum of thirty-two (32) hours a week.

(b)(1) The department shall enter into a grant agreement with the recipient of a Rural Physician Incentive Grant.

(2) Each applicant to whom a grant is awarded shall execute a written grant agreement which shall incorporate the following obligations and conditions:

(A) The recipient of a grant shall commit to provide four (4) continuous years of primary care services in accordance with § 20-12-501;

(B)(i) If any grant recipient under this subchapter does not engage in the practice of primary care services in accordance with the terms of this section, the recipient shall be obligated to repay the grant received together with interest thereon at the maximum rate allowed by Arkansas law or the federal discount rate plus five percent (5%) per year, whichever is less, the interest to accrue from the date each payment of funds was received by the recipient.

(ii) No interest shall accrue nor obligation to repay the principal sums accrued during any one (1) period of time that the recipient involuntarily serves on active duty in the United States Armed Forces; and

(C) Repayment of principal with interest shall be due and payable in full at the earliest to occur of the following events:

(i) Failure to remain in the originating rural community for four (4) continuous years for any reason other than temporary personal illness; and

(ii) Failure to practice primary care on a regularly sustained basis as defined in § 20-12-501(a).

(c) Persons accepted into and participating in the Rural Physician Incentive Grant Program before July 1, 1999, will be eligible to complete the program under the payment system established when they entered the program.

History. Acts 1991, No. 360, § 2; 1993, No. 763, § 2; 1995, No. 1089, § 3; 1999, No. 589, § 3.

SUBCHAPTER 6 — REPAYMENT OF FACULTY MEDICAL STUDENT LOANS

SECTION.

20-12-601. Purpose.

20-12-602. Eligibility.

SECTION.

20-12-603. Financial assistance — Regulations.

20-12-601. Purpose.

It is the purpose and intent of this subchapter to establish a program of financial assistance to encourage primary care physicians to accept full-time faculty positions in a University of Arkansas for Medical Sciences area health education center community or at the Department of Family and Preventive Medicine within the University of Arkansas for Medical Sciences.

History. Acts 1993, No. 1107, § 1.

20-12-602. Eligibility.

(a) Board-eligible or board-certified family physicians and board-eligible or board-certified general pediatricians who join the full-time faculty at one (1) of the University of Arkansas for Medical Sciences area health education center family practice residency program training sites or at the Department of Family and Preventive Medicine within the University of Arkansas for Medical Sciences shall be eligible to receive financial assistance under this subchapter.

(b)(1) The University of Arkansas for Medical Sciences may provide financial assistance to eligible individuals for the repayment of medical student loans or personal loans made to or on behalf of a medical student.

(2) The amount of the financial assistance shall not exceed twelve thousand dollars (\$12,000) per year for each year of service.

(3) An individual shall not be eligible for assistance for more than four (4) years.

(c) If the loan is from the Rural Medical Practice Student Loan and Scholarship Program, the financial assistance shall be paid directly to the University of Arkansas for Medical Sciences and credited to the repayment of the loan.

History. Acts 1993, No. 1107, § 2.

20-12-603. Financial assistance — Regulations.

(a) Financial assistance under this subchapter shall be made by the University of Arkansas for Medical Sciences.

(b) The University of Arkansas for Medical Sciences shall adopt reasonable regulations for the administration of this subchapter.

History. Acts 1993, No. 1107, § 2.

CHAPTER 13**EMERGENCY MEDICAL SERVICES****SUBCHAPTER.**

1. GENERAL PROVISIONS.
2. EMERGENCY MEDICAL SERVICES ACT.
3. COUNTY PROGRAMS.
4. INSECT STING AND OTHER ALLERGIC REACTIONS EMERGENCY TREATMENT ACT.
5. POISON CONTROL — DRUG INFORMATION — TOXICOLOGICAL LABORATORY SERVICES.
6. NERVE AGENTS EMERGENCY TREATMENT ACT.
7. ARKANSAS POISON AND DRUG INFORMATION CENTER.
8. TRAUMA SYSTEM ACT.
9. ARKANSAS EMERGENCY MEDICAL SERVICES DO NOT RESUSCITATE ACT.
10. AMBULANCE SERVICES.
11. CRIMINAL RECORDS CHECK.
12. VACCINATION PROGRAM FOR FIRST RESPONDERS.
13. PUBLIC ACCESS TO AUTOMATED EXTERNAL DEFIBRILLATION ACT.
14. EMERGENCY CONTRACEPTION FOR VICTIMS OF SEXUAL ASSAULT.
15. PROTECTION FROM LIFE-THREATENING DISEASE.

SUBCHAPTER

- 16. COMMUNITY PARAMEDICS.
- 17. JOSHUA ASHLEY-PAULEY ACT.
- 18. NALOXONE ACCESS ACT.

SUBCHAPTER 1 — GENERAL PROVISIONS

SECTION.

- 20-13-101. Emergency Medical Services Revolving Fund Act.
- 20-13-102. Use of special terms or abbreviations without license unlawful.
- 20-13-103. Grant requests — Division and use of funds.

SECTION.

- 20-13-104. [Repealed.]
- 20-13-105. [Repealed.]
- 20-13-106. Tourniquet access and use by first responders — Immunity — Definition.

Effective Dates. Acts 1979, No. 1090, § 9: July 1, 1979. Emergency clause provided: “It is hereby found and determined by the Seventy-Second General Assembly that the Emergency Medical Services Program of the Department of Health is in dire need of matching funds so as not to work irreparable harm upon the proper administration of the program. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health, and safety shall be in full force and effect from and after July 1, 1979.”

Identical Acts 2016 (3rd Ex. Sess.), Nos. 2 and 3, § 129: May 23, 2016. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act revises the membership and duties of certain agencies, task forces, committees, and commis-

sions and repeals other governmental entities; that these revisions and repeals of governmental entities impact the expenses and operations of state government; and that the provisions of this act should become effective as soon as possible to allow for implementation of the new provisions in advance of the upcoming fiscal year. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

RESEARCH REFERENCES

ALR. Liability for injury or death allegedly caused by activities of hospital rescue team. 64 A.L.R.4th 1200.

Application of firemen’s rule to bar re-

covery by emergency medical personnel injured in responding to or at scene of emergency. 89 A.L.R.4th 1079.

20-13-101. Emergency Medical Services Revolving Fund Act.

(a) This section shall be known as the “Emergency Medical Services Revolving Fund Act”.

(b) There is established on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a fund to be designated the “Emergency Medical Services Revolving Fund”.

(c)(1) It shall be the responsibility of the Division of Emergency Medical Services of the Department of Health to promulgate all rules and regulations for making application for the matching funds.

(2) It shall be the further responsibility of the Department of Health to review all applications and approve those that shall be eligible for moneys under the provisions of this section and as may otherwise be provided by law.

(d)(1) Funds requested by authority of this section shall be matched on a cash basis of fifty to fifty (50:50) by the applicant.

(2) The state portion shall at no time exceed ten thousand dollars (\$10,000) per county, local, commercial, or nonprofit operation, except that this limitation shall not apply when any county levies a motor vehicle tax to finance ambulance services as authorized by § 26-78-101 et seq.

(e) All moneys deposited into this fund pursuant to § 20-13-211 shall be used by the department for the following purposes:

- (1) Certification processing for emergency medical technicians;
- (2) Travel expenses related to the onsite administration of practical and written examinations of emergency medical technicians;
- (3) Maintenance of the emergency medical technician certification software program;
- (4) Educational programs for emergency medical technicians;
- (5) Continuing maintenance of the required EMT-Instructor certification for agency personnel; and
- (6) Other purposes consistent with this section.

History. Acts 1979, No. 1090, §§ 1-3, 6;
A.S.A. 1947, §§ 82-3417 — 82-3420; Acts
2005, No. 648, § 2.

20-13-102. Use of special terms or abbreviations without license unlawful.

(a) It is unlawful for any person to practice or profess to be emergency medical services personnel or to use the initials EMT, Advanced EMT, Paramedic, EMS-Instructor, EMS Instructor Trainer, or any other letters, words, abbreviations, or insignia indicating that he or she is emergency medical services personnel without first having obtained from the Department of Health a license authorizing the person to practice emergency medical services in this state.

(b) However, this section does not prohibit any person licensed under any other act in this state from engaging in the practice for which he or she is licensed nor prevent students who are enrolled in accredited EMT, Advanced EMT, Paramedic, EMS-Instructor, or EMS Instructor Trainer education programs from performing acts of emergency medical services incidental to their courses of study.

History. Acts 1985, No. 1001, § 6;
A.S.A. 1947, § 82-3421; Acts 2009, No.
689, § 5.

Publisher's Notes. Acts 1985, No.
1001, §§ 7 and 8 provided that nothing in
the act repealed Acts 1981, No. 293, § 3 or

Acts 1981 (1st Ex. Sess.), No. 23.

20-13-103. Grant requests — Division and use of funds.

(a) Grant requests for funds from the EMS Enhancement Revolving Fund shall be reviewed by the Emergency Medical Services Advisory Council specified in § 20-13-205 and recommendations for recipients of grant funds made to the Division of Emergency Medical Services of the Department of Health.

(b)(1) The grant funds shall be evenly divided between the public, private, and volunteer sectors.

(2) For the purposes of this subsection, the public sector shall include only those applicants having paid employees.

(c) The grant funds may be used to purchase or fund:

(1)(A) Ambulances for use in providing emergency medical services to the residents of Arkansas.

(B) Ambulances purchased with these funds shall meet the standards for and be registered at the I-A level or a higher level by the division;

(2)(A) Rescue vehicles for use in providing advanced life support or basic life support emergency care.

(B) Any vehicle purchased for advanced life support shall meet the standards for and be registered at the advanced rescue level by the division;

(3) Equipment required on ambulances or required to provide advanced life support or basic life support rescue services;

(4)(A) Training that leads to Arkansas licensure as emergency medical services personnel at the basic or advanced levels.

(B) Failure to obtain licensure shall result in the repayment of funds by the grantee; or

(5) Emergency medical services-related training approved by the division.

(d)(1) The funds may only be used to improve services by increasing the capability and skills of emergency medical services.

(2) Funds may not be used to maintain present status, pay salaries or daily operating expenses, contract for services, or purchase real property.

(e) The funds may not be used for new services at a lower level than an existing licensed service which has been in operation for more than one (1) year in the service area.

(f)(1) All property purchased with the funds shall be returned to the division if the licensed ambulance service ceases operations.

(2) The division shall make every effort to redistribute returned property and supplies to the replacement service or other eligible existing services within the same county.

(3) Should no eligible service exist or another eligible service not be established in the county within one (1) year, all purchases shall be redistributed by the division as needed.

(g)(1) Any vehicle or equipment purchased with these funds shall be used for its intended purpose for at least three (3) years from its date of purchase.

(2) Vehicles or equipment damaged or worn out within the three-year period shall be replaced with a like or better item at the grantee's expense.

History. Acts 1995, No. 1271, § 2; 2009, No. 689, § 6.

Cross References. EMS Enhancement Revolving Fund, § 19-5-1078.

20-13-104. [Repealed.]

Publisher's Notes. This section, concerning a durable power of attorney for health care, was repealed by Acts 2017,

No. 974, § 3. The section was derived from Acts 1999, No. 1448, §§ 1-8.

20-13-105. [Repealed.]

A.C.R.C. Notes. Identical Acts 2016 (3rd Ex. Sess.), Nos. 2 and 3, § 1, provided:

“(a) The General Assembly finds:

“(1) State government provides vital functions that impact the lives of Arkansas citizens on a daily basis;

“(2) While these functions are important, it is equally important to ensure that state government operates efficiently and effectively to eliminate unnecessary spending of tax dollars and provide timely and quality services to Arkansas citizens; and

“(3) Issues such as the administrative organization of a governmental entity, the appointment structure of a governmental entity's governing board, and extraneous

duties assigned to governmental entities hamper the operation of state government and result in unnecessary expenses and delays in the provision of state services.

“(b) It is the intent of this act to amend provisions of law applicable to certain agencies, task forces, committees, and commission to promote efficiency and effectiveness in the operations of state government as a whole.”

Publisher's Notes. This section, concerning the Antony Hobbs III Task Force on Automated External Defibrillators, was repealed by identical Acts 2016 (3rd Ex. Sess.), Nos. 2 and 3, § 40. The section was derived from Acts 2009, No. 1386, § 31; 2011, No. 1121, § 1.

20-13-106. Tourniquet access and use by first responders — Immunity — Definition.

(a) As used in this section, “first responders” means state and local law enforcement personnel, fire department personnel, and emergency medical personnel who will be deployed to bioterrorism attacks, terrorist attacks, catastrophic or natural disasters, and emergencies.

(b) The Arkansas Commission on Law Enforcement Standards and Training may certify training for law enforcement officers for approved methods and techniques on the use of mechanical and other tourniquets as recommended by the Committee on Tactical Combat Casualty Care or the Committee for Tactical Emergency Casualty Care, or both.

(c) A law enforcement officer and a first responder are immune from civil liability, criminal liability, or professional sanctions for administering a mechanical tourniquet or other tourniquet under this section if he or she is acting in good faith.

History. Acts 2015, No. 1222, § 1.

SUBCHAPTER 2 — EMERGENCY MEDICAL SERVICES ACT

SECTION.

- 20-13-201. Title.
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- 20-13-205. Emergency Medical Services Advisory Council — Creation — Members.
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SECTION.

- 20-13-208. State Board of Health — Powers and duties.
- 20-13-209. Department of Health — Powers and duties.
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Publisher's Notes. Acts 1985, No. 1001, §§ 7 and 8 provided that nothing in the act repealed Acts 1981, No. 293, § 3 or Acts 1981 (1st Ex. Sess.), No. 23.

Effective Dates. Acts 1975, No. 435, § 12: Mar. 17, 1975. Emergency clause provided: "It is hereby found and determined by the General Assembly that the development of emergency medical services in this State is essential to the public health, safety, and welfare of the people of this State, and that the immediate implementation of the provisions of this Act is necessary to establish a program of Emergency Medical Services without undue delay. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the immediate preservation of the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Acts 1975 (Extended Sess., 1976), No. 1099, § 17: Jan. 30, 1976. Emergency clause provided: "It is hereby found and determined by the Seventieth General Assembly, meeting in Extended Session, that the immediate passage of this Act is necessary to prevent irreparable harm to the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1977, No. 889, § 39: July 1, 1977. Emergency clause provided: "It is hereby

found and determined by the Seventy-First General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness of this Act on July 1, 1977 is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1, 1977 could work irreparable harm upon the proper administration and providing of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health, and safety shall be in full force and effect from and after July 1, 1977."

Acts 1987, No. 345, § 6: Mar. 20, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that the development of standards for air ambulances is essential to the public health, safety and welfare of the people of this State; that this Act is designed to provide for the development of such standards and that it is urgent that the provisions of this Act be implemented as soon as practical. Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1987, No. 1006, § 3: Apr. 14, 1987. Emergency clause provided: "It is hereby

found and determined by the General Assembly that because of the case *Ricarte v. State*, CR 86-31, a question has arisen over the validity of Act 1211 of the Extended Session of 1976; that this Act is a reenactment of the former law; and that the immediate passage of this Act is necessary to clarify the state of the law on the issue. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the immediate preservation of the public peace, health and safety, shall be in full force and effect from and after its passage and approval."

Acts 1987, No. 1021, § 3: Apr. 14, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that because of the case *Ricarte v. State*, CR 86-31, a question has arisen over the validity of Act 1099 of the Extended Session of 1976; that this Act is a reenactment of the former law; and that the immediate passage of this Act is necessary to clarify the state of the law on this issue. Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1997, No. 179, § 38: Feb. 17, 1997. Emergency clause provided: "It is hereby found and determined by the General Assembly that Act 10 of the First Extraordinary Session of 1995 abolished the Joint Interim Committee on Public Health, Welfare, and Labor and in its place established the House Interim Committee and Senate Interim Committee on Public Health, Welfare, and Labor; that various sections of the Arkansas Code refer to the Joint Interim Committee on Public Health, Welfare, and Labor and should be corrected to refer to the House and Senate Interim Committees on Public Health, Welfare, and Labor; that this act so provides; and that this act should go into effect immediately in order to make the laws compatible as soon as possible. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor

may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 1997, No. 250, § 258: Feb. 24, 1997. Emergency clause provided: "It is hereby found and determined by the General Assembly that Act 1211 of 1995 established the procedure for all state boards and commissions to follow regarding reimbursement of expenses and stipends for board members; that this act amends various sections of the Arkansas Code which are in conflict with the Act 1211 of 1995; and that until this cleanup act becomes effective conflicting laws will exist. Therefore an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 1999, No. 60, § 6: Feb. 16, 1999. Emergency clause provided: "It is hereby found and determined by the General Assembly that the present law regulating ambulance services in this State is too narrow; that uncertified and poorly equipped ambulances are lawfully operating because the present law is too narrow; that such circumstances are to the detriment of the people who are being transported by those services; that this act addresses that problem by expanding its application to provide for the regulation of all vehicles used for transporting any person by stretcher or gurney upon the streets or highways of this State; and that until this act becomes effective, the people of this State will continue to unknowingly be subject to improper transport to or from medical facilities in this State. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor

may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto.”

Acts 2001, No. 1557, § 4: July 1, 2001. Emergency clause provided: “It is found and determined by the General Assembly that the Health Task force Commission expires June 30, 2003; that the commis-

sion must report to the Legislative Council by November 1, 2002; that in order to complete all its assigned task the commission must begin work by July 1, 2001. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on July 1, 2001.”

20-13-201. Title.

This subchapter may be cited as the “Emergency Medical Services Act”.

History. Acts 1975, No. 435, § 1; A.S.A. 1947, § 82-3401.

20-13-202. Definitions.

As used in this subchapter:

(1) “Air ambulance” means an aircraft, fixed or rotary wing, utilized for on-scene responses or transports deemed necessary by a physician and licensed by the Department of Health;

(2) “Air ambulance services” means those services authorized and licensed by the department to provide care and air transportation of patients;

(3)(A) “Ambulance” means a vehicle used for transporting any person by stretcher or gurney upon the streets or highways of Arkansas, excluding vehicles intended solely for personal use by immediate family members.

(B) “Ambulance” does not include nonemergency transportation vehicles that may accommodate an individual in an upright position or Fowler’s position while in a wheelchair without the aid of emergency medical services personnel;

(4) “Ambulance services” means services authorized and licensed by the department to provide care and transportation of patients upon the streets and highways of Arkansas;

(5) “Emergency medical services” means:

(A) The transportation and medical care provided the ill or injured before arrival at a medical facility by a licensed emergency medical services personnel or other healthcare provider;

(B) Continuation of the initial emergency care within a medical facility subject to the approval of the medical staff and governing board of that facility; and

(C) Integrated medical care in emergency and nonurgent settings with the oversight of a physician;

(6)(A) “Emergency medical services personnel” means an individual licensed by the department at any level established by the rules

adopted by the State Board of Health under this subchapter and authorized to perform those services set forth in the rules.

(B) These shall include without limitation emergency medical technician, advanced emergency medical technician, paramedic, emergency medical services instructor, or emergency medical services instructor trainer;

(7) “Fowler’s position” means a position in which an individual is in an inclined position with his or her head raised between thirty to ninety degrees (30-90°);

(8) “Licensure” means official acknowledgment by the department that an individual has demonstrated competence to perform the emergency medical services required for licensure under the rules, regulations, and standards adopted by the board upon recommendation by the Emergency Medical Services Advisory Council;

(9) “Medical facility” means any hospital, medical clinic, physician’s office, nursing home, or other healthcare facility; and

(10) “Wheelchair” means a chair fitted with wheels that is not height adjustable and that is used by individuals with walking limitations as a result of illness, injury, or disability.

History. Acts 1975, No. 435, § 2; 1981, No. 293, §§ 1, 2; 1985, No. 1001, § 1; A.S.A. 1947, § 82-3402; Acts 1987, No. 345, § 1; 1999, No. 60, § 1; 2009, No. 689, § 7; 2015, No. 685, § 1; 2017, No. 1033, §§ 1, 2.

Amendments. The 2015 amendment deleted former (5) and (6), and redesignated the remaining subdivisions accordingly; added (5)(C); and substituted “State Board of Health” for “board” in (6)(A).

The 2017 amendment redesignated former (3) as (3)(A); added (3)(B); deleted “those” preceding “services” in (4); and added the definitions for “Fowler’s position” and “Wheelchair”.

20-13-203. Applicability.

(a) All municipal, county, or state-operated rescue services which choose to provide advanced life support skills to the general public but which do not transport patients except in mass casualty incidents shall comply with all rules, regulations, and standards duly promulgated under this subchapter.

(b) Furthermore, it is the intent of this subchapter that nothing contained in it applies by implication or otherwise to any municipal, county, or state-operated or state-sponsored rescue service which provides basic life support skills to the public in a “treat, no transport” fashion.

History. Acts 1975, No. 435, § 2; 1981, No. 293, §§ 1, 2; 1985, No. 1001, § 1; A.S.A. 1947, § 82-3402.

20-13-204. Penalties.

Any person violating this subchapter or any rule, regulation, or order adopted in accordance with this subchapter shall be guilty of a misdemeanor and shall be punished by a fine of not more than one

hundred dollars (\$100) or by imprisonment for a period not to exceed thirty (30) days in the county jail, or by both fine and imprisonment.

History. Acts 1975, No. 435, § 9; A.S.A. 1947, § 82-3409.

20-13-205. Emergency Medical Services Advisory Council — Creation — Members.

(a) There is created the Emergency Medical Services Advisory Council, which shall consist of nineteen (19) members with a demonstrated interest in emergency medical services, to be appointed by the Governor as follows:

(1) Four (4) members shall be licensed medical doctors of good professional standing. One (1) member shall be appointed representing each of the following areas:

(A) The Arkansas Chapter of the American College of Emergency Physicians;

(B) The Arkansas Academy of Family Physicians;

(C) The Arkansas Medical Society, Inc.; and

(D) The medical director for a licensed paramedic ambulance service;

(2) One (1) member recommended by the Arkansas Hospital Association, Inc.;

(3) One (1) member who shall be a member of the Arkansas Emergency Department Nurses Association;

(4) One (1) member who shall be a member of, and recommended by, The Arkansas Ambulance Association;

(5) One (1) member who shall be a licensed paramedic;

(6) One (1) member who shall be a licensed EMT;

(7) One (1) member representing fire department-based ambulance services;

(8) One (1) member representing emergency medical services personnel training sites who has had at least five (5) years' experience associated with emergency medical services personnel in this state;

(9) One (1) member who shall be a consumer representative who has an interest in public health and emergency medical services. The member shall be appointed by the Governor from the state at large;

(10) One (1) member who shall be sixty-five (65) years of age or more. This member shall be appointed by the Governor from the state at large and shall not belong to any other group specifically addressed in this section, with the exception of the consumer representative;

(11) One (1) member who shall represent city-based or county-based ambulance services;

(12) One (1) member who shall represent the Arkansas Association of Chiefs of Police or the Arkansas Sheriffs' Association;

(13) One (1) member representing fire service rescue operations which do not transport patients;

(14) One (1) member licensed as an attorney at law in good professional standing within this state and having a knowledge of medical and legal issues;

(15) One (1) member appointed from a list of two (2) nominees submitted by the Arkansas Emergency Medical Technicians Association; and

(16) One (1) member who shall be a certified military emergency medical technician.

(b) Members shall be appointed for terms of five (5) years.

(c) Vacancies on the council due to death, resignation, or other causes shall be filled by appointment by the Governor for the unexpired portion of the term thereof in the same manner as is provided in this section for initial appointments.

(d) Members except those employed by the state may receive expense reimbursement and stipends in accordance with § 25-16-901 et seq.

(e) The members may be removed by the Governor for neglect of duty or malfeasance in office.

History. Acts 1975, No. 435, § 3; 1985, No. 1001, § 2; A.S.A. 1947, § 82-3403; Acts 1997, No. 250, § 182; 2001, No. 1557, § 3; 2005, No. 1228, § 1; 2009, No. 689, § 8; 2017, No. 540, § 42.

Publisher's Notes. Acts 1985, No. 1001, § 2 provided, in part, that members first appointed to the council would, at

their first organizational meeting, determine by lot their respective terms in order that the terms of five members would be for one year, the terms of four members would be for two years, and the terms of four members would be for three years.

Amendments. The 2017 amendment substituted "five (5)" for "three (3)" in (b).

20-13-206. Emergency Medical Services Advisory Council — Proceedings.

(a) The Emergency Medical Services Advisory Council, within thirty (30) days after its appointment, shall organize as necessary to carry out its purposes as prescribed by this subchapter.

(b) Procedures adopted, amended, or repealed by the council shall require a majority vote of all council members.

(c)(1) At the initial organizational meeting of the council, the members shall elect from among their number a chair and a vice chair to serve for one (1) year.

(2) Annually thereafter, an organizational meeting shall be held to elect the officers.

(3) The Director of the Division of Emergency Medical Services of the Department of Health shall serve as the Executive Secretary of the Emergency Medical Services Advisory Council.

(4) Seven (7) council members shall constitute a quorum.

(d) Quarterly meetings of the council may be held. Special meetings may be called as provided by the rules of the council.

(e)(1) The executive secretary shall keep full and true records of all council proceedings and preserve all books, documents, and papers relating to the business of the council.

(2) The records of the council shall be open for inspection at all reasonable times.

(f) The council shall report in writing to the Governor on or about July 31 of each year. The report shall contain a summary of the proceedings of the council during the preceding fiscal year, a detailed and itemized statement of all revenue and of all expenditures made by or in behalf of the council, other information deemed necessary or useful, and any additional information which may be requested by the Governor.

History. Acts 1975, No. 435, § 4; A.S.A. 1947, § 82-3404; Acts 2007, No. 827, § 156.

20-13-207. Emergency Medical Services Advisory Council — Powers and duties.

(a) The Emergency Medical Services Advisory Council shall recommend for adoption by the State Board of Health rules on all matters relating to emergency medical services, including without limitation:

(1) Standards for licensure of ambulance and advanced life support rescue personnel;

(2) Standards for equipment required on ambulance and advanced life support rescue vehicles;

(3) Standards for vehicles used in patient transportation and advanced life support rescue response, including communications requirements;

(4) A statewide communications system for emergency medical services;

(5) Operational standards for providers of ambulance and advanced life support rescue services, including reporting requirements and standards for air ambulance and air ambulance services; and

(6) Procedures for summoning and dispatching aid.

(b) The Department of Health shall have evidence that the standards imposed are important to the quality of patient care.

History. Acts 1975, No. 435, § 5; 1985, No. 1001, § 3; A.S.A. 1947, § 82-3405; Acts 1987, No. 345, § 2; reen. 1987, No. 1006, § 1; 2009, No. 689, § 9.

A.C.R.C. Notes. This section was reenacted by Acts 1987, No. 1006, § 1. Acts

1987, No. 834, provided that 1987 legislation reenacting acts passed in the 1976 Extended Session should not repeal any other 1987 legislation and that such other legislation would be controlling in the event of conflict.

20-13-208. State Board of Health — Powers and duties.

(a)(1) The State Board of Health shall have the responsibility and authority to hold public hearings and promulgate and implement rules, regulations, and standards which it deems necessary to carry out the provisions of this subchapter.

(2) However, before implementing any rules, regulations, or standards, the board shall submit and obtain the review of the House

Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor or appropriate subcommittees.

(b) In addition, the board may establish appropriate rules, regulations, and standards defining or limiting the emergency medical procedures or services that may be rendered by licensed emergency medical services personnel who are authorized to legally perform these services under the conditions set forth by the board, except that before implementing any rules, regulations, and standards, the board shall submit and obtain the review of the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor or appropriate subcommittees.

History. Acts 1975, No. 435, § 6; 1981, No. 293, § 3; A.S.A. 1947, § 82-3406; Acts 1997, No. 179, § 27; 2009, No. 689, § 10; 2013, No. 1132, § 6. **Amendments.** The 2013 amendment made minor stylistic changes to the section.

20-13-209. Department of Health — Powers and duties.

The Department of Health shall have the responsibility and authority to:

- (1) Administer this subchapter;
- (2) Enforce the rules, regulations, and standards promulgated by the State Board of Health for the administration and enforcement of this subchapter;
- (3) Employ and prescribe the duties of employees as may be necessary to administer this subchapter;
- (4) Certify emergency medical services personnel through use of a national competency examination by qualified examiners upon the completion of required curriculum;
- (5) Issue and renew operational permits for each ambulance or advanced life support rescue or air ambulance service. However, no permit shall be issued unless each ambulance, advanced life support rescue unit, or air ambulance, when in use as such, conforms with the standards, requirements, and regulations as set forth by the board;
- (6) Issue initial and renewal licenses to any qualified applicant that provides emergency medical services or advanced life support rescue services, whether the applicant is an individual, partnership, corporation, or other legal entity, as well as a municipality or other unit of government;
- (7) Assist area health planning in the establishment and operation of local, municipal, county, or district emergency medical services;
- (8) In addition to collecting fees pursuant to § 20-13-211, accept public and private gifts, grants, and donations for the purpose of administering this subchapter; and
- (9) Engage in the development of dispatching capabilities for emergency ambulance services in this state. The emergency medical services provider shall make a reasonable effort to see that a patient is taken to

a physician or hospital of the patient's choice, if within a reasonable distance.

History. Acts 1975, No. 435, §§ 6-8; 5; A.S.A. 1947, §§ 82-3406 — 82-3408; 1981, No. 293, § 4; 1985, No. 1001, §§ 4, Acts 1987, No. 345, § 3.

20-13-210. Rules and standards — Review required.

(a)(1) All rules and standards relating to emergency medical services promulgated and adopted by the Emergency Medical Services Advisory Council and the State Board of Health or any other state agency or department authorized to promulgate and adopt rules to carry out this subchapter shall be submitted to the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor or appropriate subcommittees thereof for consideration before being placed in effect by the department or agency.

(2) No rules or standards promulgated to carry out this subchapter shall be enforced by any state agency or department until they have been:

(A) Submitted to and considered by the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor; and

(B) Reviewed and approved by the Legislative Council under § 10-3-309.

(b) Rules promulgated by the Emergency Medical Services Advisory Council shall receive approval of the Governor after he or she receives the review and approval of the Legislative Council before effect and enforcement.

History. Acts 1975 (Extended Sess., 1976), No. 1099, § 13; 1977, No. 491, § 1; 1977, No. 889, § 31; A.S.A. 1947, §§ 82-3405.2, 82-3405.3; reen. Acts 1987, No. 1021, § 1; 1997, No. 179, § 28; 2015, No. 1258, § 18.

A.C.R.C. Notes. Part of this section was reenacted by Acts 1987, No. 1021, § 1. Acts 1987, No. 834, provided that 1987 legislation reenacting acts passed in the 1976 Extended Session should not repeal any other 1987 legislation and that such other legislation would be controlling in the event of conflict.

Acts 2015, No. 1258, § 1, provided: "LEGISLATIVE FINDINGS. The General Assembly finds:

"(1) Amendment 92 to the Arkansas Constitution states in part: 'The General Assembly may provide by law for the review by a legislative committee of administrative rules promulgated by a state agency before the administrative rules become effective; and that administrative

rules promulgated by a state agency shall not become effective until reviewed and approved by the legislative committee charged by law with the review of administrative rules under subdivision (a)(1) of this section';

"(2) As Amendment 92 does not define the term 'state agency', the General Assembly may establish a definition by law as part of its implementation of Amendment 92;

"(3) The General Assembly at this time wishes to exclude the Arkansas State Game and Fish Commission, the State Highway Commission, the Arkansas State Highway and Transportation Department, and institutions of higher education from the definition of 'state agency' applied to the implementation of Amendment 92; and

"(4) The General Assembly or the Legislative Council reserve the right to amend the definition of 'state agency' in the future to include one (1) or all of the

Arkansas State Game and Fish Commission, the State Highway Commission, the Arkansas State Highway and Transportation Department, and institutions of higher education.”

Amendments. The 2015 amendment deleted “regulations” following “Rules” in the section heading; in (a)(1), deleted “regulations” following “rules”, “and regulations” preceding “to carry out”, and “and review” following “consideration”; deleted “regulations” following “rules” in the in-

troductory language of (a)(2); inserted the (a)(2)(A) designation; deleted “and approved for enforcement” following “considered” in (a)(2)(A); added (a)(2)(B); redesignated former (b)(1) as (b); substituted “and approval of the Legislative Council” for “of the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor or appropriate subcommittees thereof” in (b); and deleted former (b)(2).

20-13-211. Fees.

The State Board of Health may establish the fees to be charged by the Department of Health to defray the cost of administering and enforcing this subchapter, as follows:

(1) The testing fee not to exceed the cost of administering the National Registry of Emergency Medical Technicians examination;

(2)(A) The licensure fee for emergency medical services personnel, which shall not exceed twenty dollars (\$20.00).

(B) Ten dollars (\$10.00) of the licensure fee shall be credited to the Emergency Medical Services Revolving Fund.

(C) The licensure shall be valid for two (2) years;

(3) The biennial renewal of the emergency medical services personnel licensure, which shall not exceed twenty dollars (\$20.00). Ten dollars (\$10.00) of the biennial renewal shall be credited to the Emergency Medical Services Revolving Fund;

(4) The issuance and annual renewal of an operational permit for each ambulance service, which shall not exceed fifty dollars (\$50.00);

(5) The annual inspection and permitting of emergency vehicles, which shall not exceed five dollars (\$5.00) per vehicle; and

(6) The issuance and renewal of an operational license for each air ambulance service, which shall not exceed one hundred dollars (\$100).

History. Acts 1975, No. 435, § 7; 1985, Acts 1987, No. 345, § 4; 2005, No. 648, No. 1001, § 5; A.S.A. 1947, § 82-3407; § 1; 2009, No. 689, § 11.

20-13-212. Additional fees.

(a) There is imposed an additional annual fee of one hundred dollars (\$100) for the inspection and permitting of ambulances. The fee shall be collected in addition to the fee provided in § 20-13-211(5).

(b) There is imposed an annual fee of five hundred dollars (\$500) for the issuance or renewal of an operational permit for an ambulance service, advanced life support rescue service, or air ambulance service. The fee required by this subsection shall be in addition to all other requirements for the issuance or renewal of an operational permit and shall be required in each county in which the ambulance service, including air ambulance services, has an operational base.

(c)(1) The fees established by this section shall be collected by the Department of Health.

(2) The department shall deposit the fees with the Treasurer of State, and the fees shall be credited to the Arkansas Medicaid Program Trust Fund.

History. Acts 1995, No. 1275, § 1;
1999, No. 38, § 1.

20-13-213. Ambulance standards.

All ambulances operating in this state shall meet all standards prescribed by and under this subchapter and be licensed under this subchapter, and all personnel operating ambulances in this state shall meet the standards prescribed under this subchapter.

History. Acts 1999, No. 60, § 2.

20-13-214. Military emergency medical personnel.

(a) Military personnel who return to the State of Arkansas following active duty and who received emergency medical training on active duty shall be granted initial licensure from the Department of Health as emergency medical services personnel under this subchapter, upon proof from the military that the individual received emergency medical training while on active duty.

(b) Military personnel licensed under this section shall pay the fees for biennial renewal of the emergency medical services personnel license required under this subchapter.

History. Acts 2005, No. 1674, § 1;
2009, No. 689, § 12.

20-13-215. Award of flag upon death — Definition.

(a) When a person licensed by the Division of Emergency Medical Services of the Department of Health dies in the course of employment, in recognition of and appreciation for the service of the deceased person, the Department of Health may award one (1) United States flag to the deceased person's spouse or family.

(b) As used in this section, "in the course of employment" means at any time when a person is:

(1) On duty in the capacity for which he or she is licensed by the department; or

(2) Performing an act ordinarily performed in the capacity for which he or she is licensed by the department, although the person is not on duty at the time.

(c) This section does not limit or deny the right of any person or the person's survivors to any other benefits provided by law.

History. Acts 2015, No. 1184, § 2.

SUBCHAPTER 3 — COUNTY PROGRAMS

SECTION.

- 20-13-301. Legislative intent.
- 20-13-302. Act supplemental.
- 20-13-303. Establishment.
- 20-13-304. Referendum — Effective date of ordinance.

SECTION.

- 20-13-305. Financing.
- 20-13-306. Service charges for preexisting programs.
- 20-13-307. Discontinuance.

Cross References. Legislative powers of county government, § 14-14-801 et seq.

Effective Dates. Acts 1980 (1st Ex. Sess.), No. 40, § 4: Jan. 25, 1980. Emergency clause provided: "It is hereby found and determined by the General Assembly that the procedure established in Act 51 of 1979 for the collection of assessments made by counties for providing emergency medical services to residents creates some serious problems especially with respect to service charges to be billed in 1980; that there is some confusion concerning the vote necessary to ratify an ordinance adopted by the quorum court to establish emergency medical services; that unless the Emergency Medical Services Act is clarified, some counties in the State may lose emergency medical services funding and consequently may not be able to furnish emergency medical services to their residents; that this Act is immediately necessary to permit the quorum court to determine by ordinance the method of collection of emergency medical services charges, and to clarify the provisions of the Emergency Medical Services Act in order to assure that the various counties in the State will be able to continue to furnish emergency medical services to their citizens, and should be given effect immediately. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall

be in full force and effect from and after its passage and approval."

Acts 1980 (1st Ex. Sess.), No. 68, § 4: Feb. 6, 1980. Emergency clause provided: "It is hereby found and determined by the General Assembly that the procedure established in Act 51 of 1979 for the collection of assessments made by counties for providing emergency medical services to residents creates some serious problems especially with respect to service charges to be billed in 1980; that there is some confusion concerning the vote necessary to ratify an ordinance adopted by the quorum court to establish emergency medical services; that unless the Emergency Medical Services Act is clarified, some counties in the State may lose emergency medical services funding and consequently may not be able to furnish emergency medical services to their residents; that this Act is immediately necessary to permit the quorum court to determine by ordinance the method of collection of emergency medical services charges, and to clarify the provisions of the Emergency Medical Services Act in order to assure that the various counties in the State will be able to continue to furnish emergency medical services to their citizens, and should be given effect immediately. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

CASE NOTES

Applicability.

Section 14-14-801 et seq. gives the quorum court of any county the authority to provide for emergency medical services, but the authority created under § 14-14-801 et seq. is governed and limited by the procedural requirements of this subchap-

ter. *Vandiver v. Washington County*, 274 Ark. 561, 628 S.W.2d 1 (1982).

Section 14-14-801 et seq. and this subchapter were not intended to provide alternative procedures for the establishment of emergency medical services by a county, since to hold that the laws were

intended to provide alternative methods would effectively render this subchapter a nullity, as there would be no reason for a quorum court to choose the more arduous route required by this subchapter when it

could accomplish the same result more easily under § 14-14-801 et seq. *Vandiver v. Washington County*, 274 Ark. 561, 628 S.W.2d 1 (1982).

20-13-301. Legislative intent.

It is the intent of this subchapter to authorize the quorum court in any county to provide emergency medical services for residents of the county or any designated area of the county and to provide for levying service charges upon residents of the area to provide funds for the purchase of equipment, the maintenance and operation of equipment, and the payment for personal services necessary to provide the services.

History. Acts 1979, No. 51, § 1; A.S.A. 1947, § 82-3410.

20-13-302. Act supplemental.

The procedures prescribed in this subchapter for the establishment of an emergency medical services program and the furnishing of emergency medical services shall be supplemental to and shall not be construed to repeal or modify any law presently in existence relating to the furnishing of such services.

History. Acts 1979, No. 51, § 7; A.S.A. 1947, § 82-3416.

CASE NOTES

Cited: *Vandiver v. Washington County*, 274 Ark. 561, 628 S.W.2d 1 (1982).

20-13-303. Establishment.

(a) The quorum court of any county on its own motion or upon petition of ten percent (10%) of the electors of the county or any designated area of the county may establish by ordinance a system to provide emergency medical services to the residents of the county or the designated area.

(b)(1) When a quorum court proposes to enact an ordinance to provide emergency medical services, whether on its own motion or upon petition of electors, it shall set a date for a public hearing on the question and shall cause notice of the time and place of the hearing to be published in a newspaper of general circulation in the county or in the area proposed to be served.

(2) All interested parties residing in the county or in the designated area shall have an opportunity to appear and be heard either for or against the establishment of the system.

(3) At the next meeting of the quorum court after the hearing, the quorum court may adopt an ordinance establishing the emergency medical services system for the county or the designated area of the county or may refuse to act further on the matter.

(c) If after the hearing the quorum court enacts an ordinance establishing a system, the ordinance shall specifically describe the area to be included within the system, shall describe the services to be provided the residents of the area, and shall specifically state the estimated cost of the services and the proposed method of financing the services, and such other matters as the quorum court deems appropriate to publicly advise residents of the county or the designated area of the purposes and costs of the system established in the ordinance.

History. Acts 1979, No. 51, § 2; A.S.A. 1947, § 82-3411.

CASE NOTES

ANALYSIS

Applicability.
General County Powers Law.
Procedural Defects.

Applicability.

The requirements of this section apply only when emergency medical services are to be financed by imposition of a service charge on potential users of the service or by a separate mileage assessment; where the services were to be funded by a county sales tax, there was no violation. *West Wash. County Emergency Medical Servs. v. Washington County*, 313 Ark. 76, 852 S.W.2d 137 (1993).

The General Assembly intended the procedural requirements of this section to apply to a county's establishment of an emergency medical service which is financed by a service charge rather than by county-wide taxation. *West Wash. County Emergency Medical Servs. v. Washington County*, 313 Ark. 76, 852 S.W.2d 137 (1993).

General County Powers Law.

The general county powers law found in § 14-14-801 is circumscribed by this section when the method of financing a county emergency medical service is by service charge. *West Wash. County Emergency Medical Servs. v. Washington County*, 313 Ark. 76, 852 S.W.2d 137 (1993).

Procedural Defects.

Where the procedures followed by a quorum court in enacting county ordinance regarding emergency medical services substantially complied with the hearing, notice and referendum requirements of this subchapter, and the extensive news treatment given the ordinance afforded the electors actual notice of what they were voting on, any procedural defects in the enactment of the ordinance were cured by the referendum election at which the voters decisively approved the ordinance. *Vandiver v. Washington County*, 274 Ark. 561, 628 S.W.2d 1 (1982).

20-13-304. Referendum — Effective date of ordinance.

(a) Within ten (10) days after the enactment of the ordinance, a copy of the ordinance in its entirety shall be published in a newspaper of general circulation in the county or in the designated area.

(b) The ordinance shall be subject to the referendum which may be exercised in the manner prescribed in Arkansas Constitution, Amendment 7, and laws enacted pursuant to Arkansas Constitution, Amendment 7, and the ordinance shall not be effective until the expiration of

the time prescribed by the Arkansas Constitution and laws for the filing of referendum petitions.

(c)(1) If at the expiration of the period for filing referendum petitions no petitions have been filed, the ordinance shall become effective.

(2) If referendum petitions have been filed, the ordinance shall be held in abeyance until the election thereon is conducted and the results determined.

(d)(1) If at the election a majority of the qualified electors of the county or the designated area voting on the question vote for the ordinance, it shall become effective.

(2) If a majority of the qualified electors voting on the question at the election vote against the ordinance, it shall be deemed rejected and shall have no force or effect.

History. Acts 1979, No. 51, § 3; 1980 Sess.), No. 68, § 1; A.S.A. 1947, § 82-3412. (1st Ex. Sess.), No. 40, § 1; 1980 (1st Ex.

CASE NOTES

Procedural Defects.

Where the procedures followed by a quorum court in enacting county ordinance regarding emergency medical services substantially complied with the hearing, notice and referendum requirements of this subchapter and the extensive news treatment given the ordinance

afforded the electors actual notice of what they were voting on, any procedural defects in the enactment of the ordinance were cured by the referendum election at which the voters decisively approved the ordinance. *Vandiver v. Washington County*, 274 Ark. 561, 628 S.W.2d 1 (1982).

20-13-305. Financing.

(a) Emergency medical services to be provided the residents of any county or any designated area of the county pursuant to the provisions of this subchapter may be financed by service charges levied in the ordinance establishing the service.

(b)(1) The service charges may be assessed and collected on a per capita, per household, or per unit of service basis or a combination of any of these, as may be determined by the quorum court, and shall be collected in such manner as may be prescribed by ordinance of the quorum court.

(2) If the quorum court elects by ordinance to have the service charges entered on ad valorem tax notices and collected by the county collector at the time of collecting real and personal property taxes, the collector shall not accept payment of any ad valorem taxes unless the taxpayer at the same time pays any service charges billed to him or her to finance emergency medical services.

(c) All funds derived from the levy of service charges to support the furnishing of emergency medical services in the county or designated area shall be used only for the purposes for which levied, and a separate account shall be maintained in the county treasury in which all funds shall be deposited.

(d)(1) The funds shall be expended only on appropriation of the quorum court and shall be subject to the same accounting and disbursement procedures and requirements as other county funds.

(2) A quorum court may expend the funds directly to an emergency medical services provider selected for the area without observing the accounting requirements of other county funds if:

(A) The quorum court appropriates the funds for that purpose;

(B) The voters of an emergency medical services district have approved the collection of service charges by placement of those fees on the ad valorem tax notices; and

(C) The quorum court determines by resolution that the annual cost of providing emergency medical services to the district exceeds the annual amount collected as service charges by the placement of the service charges on the ad valorem tax notices.

History. Acts 1979, No. 51, § 4; 1980 (1st Ex. Sess.), No. 40, § 2; 1980 (1st Ex. Sess.), No. 68, § 2; A.S.A. 1947, § 82-3413; Acts 2013, No. 970, § 1.

Amendments. The 2013 amendment added (d)(2).

CASE NOTES

ANALYSIS

Fees.
Financing.
Fees.

Where a county ordinance imposed an annual fee on each household, except those served by another company, to meet the cost of providing emergency medical services to the area, the levy imposed by the ordinance was properly held to be a fee and not a tax since the levy was imposed for a particular purpose, it was for a

service, the funds were separately allocated to pay for that service, and householders similarly served by another provider were relieved of the levy. *Vandiver v. Washington County*, 274 Ark. 561, 628 S.W.2d 1 (1982).

Financing.

This section states services may be financed by service charges and does not refer to any other form of financing. *West Wash. County Emergency Medical Servs. v. Washington County*, 313 Ark. 76, 852 S.W.2d 137 (1993).

20-13-306. Service charges for preexisting programs.

(a) In any county in which a system of emergency medical services has been established before July 20, 1979, the quorum court of the county may levy service charges on residents of the county or designated area of the county in which services are provided to finance or assist in financing the services.

(b) The ordinance levying service charges to finance emergency medical services programs established before July 20, 1979, shall be subject to the same notice and hearing requirements and shall be subject to referendum in the same manner as is provided in this subchapter for the ordinance establishing a system of emergency medical services.

History. Acts 1979, No. 51, § 6; A.S.A. 1947, § 82-3415.

CASE NOTES

Cited: Vandiver v. Washington County, 274 Ark. 561, 628 S.W.2d 1 (1982).

20-13-307. Discontinuance.

(a) The quorum court of any county which has established a system of emergency medical services for the residents of the county or any designated area pursuant to the authority granted in this subchapter may, on its own motion or on petition of a majority of the qualified electors of the county or designated area, discontinue the furnishing of emergency medical services in the county or area and discontinue the levy of service charges in the area.

(b) However, the services shall not be discontinued until a public hearing is held at which persons residing in the county or the designated area have an opportunity to appear in behalf of or in opposition to the discontinuance of the services. The time and place of the hearing shall be published in a newspaper of general circulation in the county or designated area at least ten (10) days before the date thereof.

(c) When an emergency medical services program is discontinued in the manner authorized in this section, the service charges authorized by the ordinance which established the program shall continue to be collected until all outstanding debts of the program have been paid.

History. Acts 1979, No. 51, § 5; A.S.A. 1947, § 82-3414.

SUBCHAPTER 4 — INSECT STING AND OTHER ALLERGIC REACTIONS EMERGENCY TREATMENT ACT

SECTION.

- 20-13-401. Title.
- 20-13-402. Purpose.
- 20-13-403. Definitions.
- 20-13-404. Eligibility for certificate.
- 20-13-405. Authority of certificate holder.

SECTION.

- 20-13-406. Immunity.
- 20-13-407. Administration of subchapter.
- 20-13-408. Auto-injectable epinephrine use by an authorized entity.

Effective Dates. Acts 1983, No. 436, § 11: Mar. 13, 1983. Emergency clause provided: "It is hereby found and declared by the General Assembly of the State of Arkansas that it is necessary to provide for emergency treatment to certain individuals when a physician is not immediately available to administer life-saving

treatment to those persons who have severe adverse reactions to insect stings. Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

20-13-401. Title.

This subchapter shall be known and cited as the “Insect Sting and Other Allergic Reactions Emergency Treatment Act”.

History. Acts 1983, No. 436, § 1; A.S.A. 1947, § 82-4501; Acts 2009, No. 684, § 1.

20-13-402. Purpose.

It is the purpose of this subchapter to provide a means of authorizing certain individuals to administer treatment to those persons who have severe adverse reactions to insect stings and other allergic reactions when a physician is not immediately available.

History. Acts 1983, No. 436, § 2; A.S.A. 1947, § 82-4502; Acts 2009, No. 684, § 1.

20-13-403. Definitions.

As used in this subchapter:

(1) “Authorized entity” means an entity or organization at which or in connection with which allergens capable of causing an anaphylactic reaction may be present, including without limitation:

- (A) A restaurant;
- (B) An amusement park; and
- (C) A sports arena;

(2) “Auto-injectable epinephrine” means a single-use device used for the automatic injection of a premeasured dose of epinephrine into the human body;

(3) “Certificate” means a certificate issued under this subchapter to authorize the receipt, possession, and administration of prescribed auto-injectable epinephrine;

(4) “Expected user” means an authorized entity’s employee or agent who is responsible for the storage, maintenance, and general supervision of auto-injectable epinephrine acquired by the authorized entity;

(5) “Healthcare professional” means a licensed physician, chiropractor, dentist, optometrist, podiatrist, or other licensed healthcare professional;

(6) “Physician” means an individual licensed to practice medicine in the State of Arkansas under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.; and

(7) “Self-administration” means a person’s discretionary use of auto-injectable epinephrine pursuant to a prescription or written direction from a healthcare professional.

History. Acts 1983, No. 436, § 3; A.S.A. 1947, § 82-4503; Acts 2015, No. 1108, § 1.

Amendments. The 2015 amendment substituted “Definitions” for “Definition” in the section heading; added (1) through

(5); designated the definition of “Physician” as (6); in (6), substituted “an individual” for “a natural person” and “under” for “pursuant to”; and added (7).

20-13-404. Eligibility for certificate.

A person may receive a certificate under this subchapter only if the person:

- (1) Is eighteen (18) years of age or older;
- (2) Has, or reasonably expects to have, regular contact with at least one (1) other person as a result of the person's relationship or occupational or volunteer status, including without limitation:
 - (A) A parent;
 - (B) A camp counselor;
 - (C) A scout leader;
 - (D) A school nurse, school teacher, or other school employee;
 - (E) A forest ranger;
 - (F) A tour guide;
 - (G) A chaperone; or
 - (H) An authorized entity; and
- (3)(A) Has been properly instructed by a physician or has completed an anaphylaxis training program conducted by a nationally recognized organization experienced in training laypersons in emergency health treatment or other person approved by the Department of Health.
- (B) The instruction shall include recognition of the symptoms of systemic reactions to insect stings and other allergic reactions and the proper administration of an injection of epinephrine.

History. Acts 1983, No. 436, §§ 4, 5; A.S.A. 1947, §§ 82-4504, 82-4505; Acts 2009, No. 684, § 2; 2013, No. 757, § 2; 2013, No. 1437, § 2; 2015, No. 1108, § 1.

Amendments. The 2013 amendment by No. 757, in (2), substituted "such as" for "for example" and "school nurses, public school teachers" for "schoolteachers".

The 2013 amendment by No. 1437, in (2), substituted "including without limitation" for "such as", deleted "public" following "school nurses", and inserted "other school employees".

The 2015 amendment rewrote the section.

20-13-405. Authority of certificate holder.

(a) A certificate issued pursuant to this subchapter shall authorize the certificate holder to receive, upon presentation of the certificate, from any physician a prescription for premeasured doses of epinephrine and the necessary paraphernalia for administration.

(b) The certificate also shall authorize the certificate holder to possess, provide, and administer in an emergency situation when a physician is not immediately available the prescribed epinephrine to a person who:

- (1) Has contact with the certificate holder as a result of the certificate holder's relationship or occupational or volunteer status under § 20-13-404(2); and
- (2) Appears to be suffering a severe adverse reaction to an insect sting or other allergic reaction.

History. Acts 1983, No. 436, § 7; A.S.A. 1947, § 82-4507; Acts 2009, No. 684, § 3; 2015, No. 1108, § 2.

Amendments. The 2015 amendment, in (b), inserted “provide” and substituted

“a person who” for “persons suffering a severe adverse reaction to an insect sting or other allergic reaction”; added (b)(1) and (2); and deleted (c).

20-13-406. Immunity.

(a) A person or entity that in good faith renders emergency care or treatment by the use of auto-injectable epinephrine is immune from civil liability resulting from:

(1) The emergency care or treatment; and

(2) Any good faith act or omission to provide or arrange for further medical treatment.

(b) A person or entity granted immunity under subsection (a) of this section includes without limitation:

(1) A physician or medical facility that distributes auto-injectable epinephrine or issues a certificate under this subchapter;

(2) A person or entity that provides auto-injectable epinephrine training to an expected user or authorized entity;

(3) A person or entity responsible for the location where the auto-injectable epinephrine is located or used; and

(4) A certificate holder.

(c) The immunity under subsection (a) of this section does not apply if the cause of action results from gross negligence or willful or wanton misconduct.

(d) Immunity under this section is in addition to the immunity provided to an individual acting as a “Good Samaritan” under the provisions of § 17-95-101.

History. Acts 1983, No. 436, § 8; A.S.A. 1947, § 82-4508; Acts 2015, No. 1108, § 3.

Amendments. The 2015 amendment rewrote the section.

20-13-407. Administration of subchapter.

(a) The Department of Health shall prepare a certificate form for use by a physician as authorized under this subchapter.

(b)(1) A copy of a certificate issued under this subchapter shall be forwarded by the issuing physician to the department.

(2) The department shall maintain the copy on file and make it available for public inspection.

History. Acts 1983, No. 436, § 6; A.S.A. 1947, § 82-4506; Acts 2015, No. 1108, § 3.

Amendments. The 2015 amendment, in (a), substituted “Department of Health” for “Division of Health of the Department of Health and Human Services”, substituted “a certificate” for “the appropriate certificate”, and substituted “for use by a physician as authorized under” for “to be

available to physicians upon request to accomplish the purposes of”; redesignated (b) as (b)(1); in (b)(1), substituted “a certificate” for “all certificates”, substituted “under” for “pursuant to”, substituted “department” for “division”, and deleted “to be maintained on file and subject to public inspection” following “department”; and added (b)(2).

20-13-408. Auto-injectable epinephrine use by an authorized entity.

(a) In order to ensure the public health and safety, an authorized entity that acquires auto-injectable epinephrine shall ensure that:

(1) An expected user:

(A) Completes appropriate knowledge and skills courses at least one (1) time every two (2) years in anaphylaxis and auto-injectable epinephrine use; and

(B) Obtains a certificate under this subchapter;

(2) The auto-injectable epinephrine is maintained according to the manufacturer's operational guidelines and instructions in a locked, secure location; and

(3) A person who renders emergency care or treatment to a person having an anaphylactic reaction by using auto-injectable epinephrine activates the emergency medical services system as soon as possible and immediately reports the use of auto-injectable epinephrine to the medical provider responding to the emergency.

(b) An authorized entity and its expected users may:

(1) Obtain a prescription in the name of the authorized entity for epinephrine auto-injectors and acquire epinephrine auto-injectors under the prescription;

(2) Provide auto-injectable epinephrine for immediate self-administration to an individual who the authorized entity or expected user believes in good faith is experiencing anaphylaxis, regardless of whether the individual has a prescription for auto-injectable epinephrine or has previously been diagnosed with an allergy; and

(3) Administer auto-injectable epinephrine directly to an individual who the authorized entity or expected user believes in good faith is experiencing anaphylaxis, regardless of whether the individual has a prescription for auto-injectable epinephrine or has been previously diagnosed with an allergy.

(c) An authorized entity that possesses and makes available auto-injectable epinephrine shall:

(1)(A) Submit to the Department of Health a report of each incident on the authorized entity's premises in which the authorized entity provides or administers auto-injectable epinephrine.

(B) The department annually shall publish a report that summarizes and analyzes the reports submitted under this subdivision (c)(1); and

(2) Notify an agent of emergency communications, 911, or vehicle dispatch center of the existence, location, and type of auto-injectable epinephrine.

History. Acts 2015, No. 1108, § 4.

SUBCHAPTER 5 — POISON CONTROL — DRUG INFORMATION — TOXICOLOGICAL LABORATORY SERVICES

SECTION.

- 20-13-501. Legislative finding.
- 20-13-502. Purpose of program.
- 20-13-503. Definitions.
- 20-13-504. Penalties.
- 20-13-505. Authority of director.
- 20-13-506. Advisory committee — Creation.

SECTION.

- 20-13-507. Structure and design of program.
- 20-13-508. Designation of personnel.
- 20-13-509. Compensation for student workers.
- 20-13-510. Personnel immunity.
- 20-13-511. Recordkeeping and reporting.

A.C.R.C. Notes. Acts 1991, No. 796, § 9, transferred the poison control and drug information portions of the Poison Control-Drug Information — Toxicological Laboratory Services Unitary System (§ 20-13-501 et seq.) to the College of Pharmacy of the University of Arkansas for Medical Sciences. The toxicological laboratory services are to remain the responsibility of the Arkansas Department of Health.

Cross References. Labelling of poisons, §§ 17-92-411, 20-62-101.

Records of poison sales, § 17-92-410.

Strychnine, restrictions on sale, § 20-62-102.

Effective Dates. Acts 1975, No. 600, § 12: Mar. 28, 1975. Emergency clause provided: "It is hereby determined and declared by the General Assembly that the increasing need among Arkansas medical and allied health professionals for the kind of toxicology services created within this PC-DI-TL system is so great that public health and safety require that immediate steps be taken to insure immediate passage of this act to protect Arkansas citizens from the danger posed by injudicious use of dangerous substances, therefore, an emergency is hereby declared to exist and this Act, necessary for preservation of the public peace, health, and safety, shall be in full force from and after its passage and approval."

Acts 1983, No 793, § 3: July 1, 1983. Emergency clause provided: "It is hereby found and determined by the General Assembly that this Act should become effective at the beginning of the next fiscal year and that unless this emergency clause is adopted this Act may not become effective until after that date. Therefore, an emergency is hereby declared to exist and this

Act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 1983."

Acts 1991, No. 796, § 13: July 1, 1991. Emergency clause provided: "It is hereby found and determined by the Seventy-Eighth General Assembly that the public health and safety require that immediate steps be taken to insure immediate passage of this act to protect the citizens of this state from the danger posed by injudicious use of dangerous substances; that this act should become effective at the beginning of the next fiscal year and that unless this emergency clause is adopted this act may not become effective until after that date. Therefore an emergency is hereby declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 1991."

Acts 1997, No. 250, § 258: Feb. 24, 1997. Emergency clause provided: "It is hereby found and determined by the General Assembly that Act 1211 of 1995 established the procedure for all state boards and commissions to follow regarding reimbursement of expenses and stipends for board members; that this act amends various sections of the Arkansas Code which are in conflict with the Act 1211 of 1995; and that until this cleanup act becomes effective conflicting laws will exist. Therefore an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the

period of time during which the Governor shall become effective on the date the last may veto the bill. If the bill is vetoed by house overrides the veto.”
the Governor and the veto is overridden, it

20-13-501. Legislative finding.

(a) The General Assembly finds and declares that because of the inherent threat of human danger posed by injudicious use, or misuse, of dangerous substances, the physicians and allied health professionals who provide healthcare services for Arkansas citizens are in need of emergency poison control and drug information and toxicological laboratory services sufficient to provide, on a twenty-four-hour coverage basis, reliable, accurate, and qualified professional judgments and responses to requests for emergency poison control and drug information data and emergency toxicological laboratory services such as analysis of blood, urine, vomitus, and gastric lavage for substance identification, and that public health and welfare require such services.

(b) The General Assembly further finds and declares that legislation is required to authorize and provide effective practical delivery of emergency poison control and drug information and toxicological laboratory services judgments and responses to physicians and allied health professionals who deliver healthcare services within this state.

History. Acts 1975, No. 600, § 1; A.S.A. 1947, § 82-3501.

20-13-502. Purpose of program.

The purpose of this subchapter shall be to implement a statewide emergency poison control-drug information-toxicological laboratory services program (PC-DI-TL) designed and structured to deliver, on a twenty-four-hour coverage basis, reliable, accurate, qualified professional judgments and responses to requests for emergency poison control-drug information data and toxicological laboratory services, such services to include, but not be limited to, analysis of blood, urine, vomitus, and gastric lavage for substance identification purposes.

History. Acts 1975, No. 600, § 2; A.S.A. 1947, § 82-3502.

20-13-503. Definitions.

As used in this subchapter:

(1) “Category I response” within the toxicology laboratory component means a response delivered within six (6) hours after receipt of the sample to be identified;

(2) “Category II response” within the toxicology laboratory component means a response delivered within twelve (12) hours after receipt of the sample to be identified;

(3) “Department” means the Department of Health;

(4) "Director" means the Director of the Department of Health;

(5) "Emergency request" means a request for emergency assistance initiated by any licensed Arkansas medical or allied health professional when life-jeopardizing circumstances require PC-DI-TL services to effectuate treatment;

(6) "Emergency sample" means any sample, nonroutine in nature, submitted to the toxicology laboratories for analysis as a necessary clinical adjunct to emergency patient treatment;

(7) "Information retrieval" within the PC-DI-TL context means a system which includes, but is not limited to:

(A) DEC-10 UAMS-Pharmacy computer terminal directly interfaced with the computer facility of the University of Arkansas for Medical Sciences facility containing six thousand (6,000) listings of the most commonly contacted poisons;

(B) A UAMS-Pharmacy microfiche system containing seventy-six thousand (76,000) listings of different products and management information together with extensive product identification information;

(C) A UAMS-Pharmacy "Tox-file", a compilation of commercial products published by the National Clearinghouse for Poison Control Centers;

(D) A classic, widely accepted UAMS-Pharmacy resource reference, Gleason, Gosselin, & Hodge, Clinical Toxicology of Commercial Products;

(E) UAMS-Pharmacy toxicity and overdosage manuals provided by national pharmaceutical firms;

(F) UAMS-Pharmacy resource toxicological library treating all subject matter for less common toxic materials, chemicals, and plants;

(G) UAMS-Pharmacy direct contact with medical directors of pharmaceutical manufacturing companies;

(H) UAMS-Library "MEDLINE" and "TOXLINE" computer database systems embracing bibliographic references to medical toxicological literature;

(I) UAMS-Library manual literature search, a trained searcher's use of library bibliographic sources such as indices, abstracts, and bibliographies to provide information requested;

(J) UAMS-Library drug reference search, a trained searcher's use of library drug lists, compendia, and other books to locate factual information of a drug, food, or other chemical substance; and

(K) UAMS-Library, de Haen, Drugs in Use, excerpted data from published literature on clinical use of a drug showing scope of study, drug used, dosage, concomitant therapy, disease condition, incidence or absence of adverse reactions, and description of effectiveness. This information is available on approximately two thousand (2,000) drugs;

(8) "Medical or allied health professional" means a licensed physician, nurse, pharmacist, dentist, psychologist, veterinarian, hospital administrator, hospital chemist, technician, or institutional chemist;

(9) “PC-DI-TL services system” means the Poison Control-Drug Information-Toxicological Laboratory Services Unitary System with three (3) definite and permanent components: UAMS-Pharmacy, UAMS-Library, and the Chemistry Branch of the Public Health Laboratory of the Department of Health;

(10) “Toxicology laboratory services” means those services provided the PC-DI-TL services system by the Chemistry Branch of the Public Health Laboratory of the Department of Health, which is that permanent component within the PC-DI-TL services system charged with toxicology laboratory services responsibility;

(11) “UAMS-Library” means the Library of the University of Arkansas for Medical Sciences, which is that permanent component within the unitary system charged with nonemergency poison and drug information responsibility; and

(12) “UAMS-Pharmacy” means the Department of Pharmacology of the College of Pharmacy of the University of Arkansas for Medical Sciences, which is that permanent component within the unitary system charged with emergency poison and drug information responsibility.

History. Acts 1975, No. 600, § 3; A.S.A. 1947, § 82-3503; Acts 2017, No. 264, § 1.

Amendments. The 2017 amendment substituted “Department of Health” for “Division of Health of the Department of

Health and Human Services” in (9) and (10); and, in (10), inserted “PC-DI-TL services” and substituted “PC-DI-TL services system charged” for “unitary system charged”.

20-13-504. Penalties.

Any individual who shall fraudulently represent himself or herself to be a person entitled to invoke the services of the PC-DI-TL system when such is not the case or any person who attempts to obtain information later put to illegal use in any way shall be deemed guilty of a misdemeanor and upon conviction in any court of competent jurisdiction shall be fined a sum not to exceed five hundred dollars (\$500) or imprisoned for a period not to exceed six (6) months, or both.

History. Acts 1975, No. 600, § 9; A.S.A. 1947, § 82-3509.

20-13-505. Authority of director.

(a) The Director of the Department of Health may:

(1) Employ any coordination measures necessary to effectuate the purposes of this subchapter within and among the responsible components;

(2) Engage in any educational program or effort undertaken in partnership with county or municipal governmental agencies or other groups if, in his or her judgment, such activity would effectuate the purposes of this subchapter;

(3) Authorize any component within the system to employ experts and consultants and compensate those individuals at rates determined

by the director in consultation with component representatives of the University of Arkansas for Medical Sciences; and

(4) Engage in programs of experimental or demonstration research.

(b) Additionally, the director may accept and administer loans, grants, or other funds and gifts, conditional or otherwise, from the United States Government and any other public or private sources. In all such transactions, the PC-DI-TL system shall remain unitary, and the director shall allow no function which might require the separation of the components.

(c) The director shall have full authority, in consultation with the two (2) University of Arkansas for Medical Sciences components of the PC-DI-TL system, to formulate, promulgate, adopt, amend, and enforce rules, regulations, and regulatory standards necessary to effectuate this subchapter in a way consistent with § 10-3-309.

History. Acts 1975, No. 600, §§ 6, 7;
A.S.A. 1947, §§ 82-3506, 82-3507.

20-13-506. Advisory committee — Creation.

(a)(1) The Department of Health may appoint an advisory committee to assist in the development and review of regulations promulgated under the authority of this subchapter.

(2) The committee shall consist of an uneven number of persons, not to exceed seven (7), appointed by the Director of the Department of Health.

(b)(1) Membership on the advisory committee shall include representatives qualified by experience and affiliation to represent the viewpoints of persons and groups most likely to become participants within the PC-DI-TL services components of the established program.

(2) The advisory committee may include representatives from the medical and allied health professional community, individuals with poison control, drug information, and toxicological services knowledge and expertise, state and local governmental officials, and public interest groups.

(3) In the selection of members, the director shall appoint only those persons with professional expertise in poison control, drug information, toxicological laboratory services, or other health and safety fields.

(c) Members of the advisory committee may receive expense reimbursement in accordance with § 25-16-901 et seq.

(d) Any reasonable administrative and technical assistance required by the committee shall be provided by the director in consultation with the UAMS-Pharmacy and UAMS-Library permanent components of the PC-DI-TL program.

(e) The advisory committee may seek advice and information from interested knowledgeable persons or governmental agencies within or without the state to assist in policy determinations and regulatory standards.

History. Acts 1975, No. 600, § 4; A.S.A. 1947, § 82-3504; Acts 1997, No. 250, § 183.

20-13-507. Structure and design of program.

(a)(1)(A) The time-response design shall embrace two (2) broad, major, selective categories inherent in the threat of human danger posed by injudicious use or misuse of dangerous substances.

(B) A Category I response shall be delivered within six (6) hours after receipt of the sample to be identified.

(C) A Category II response shall be delivered within twelve (12) hours after receipt of the sample to be identified.

(D) All responses shall be followed in each instance by a written confirmation report at the earliest practicable date.

(2) Determinative category substances shall be:

CATEGORY I (6 hrs.)	CATEGORY II (12 hrs.)
1) barbiturates	1) pesticides
2) narcotics	2) heavy metals
3) amphetamines	3) other substances
4) salicylates	
5) phenothiazine	
6) alcohol	
7) chloral hydrate	
8) Librium	
9) Valium	
10) Placidyl	
11) Meprobamate	
12) Methaqualone	
13) Glutethimide	
14) other drugs	

(b) Under the authority of this subchapter, participating hospital emergency room personnel shall be qualified and trained to use spot tests and thin-layer chromatography in conducting blood and urine presumptive chemical tests for drugs and harmful chemicals as well as quick scanning examinations for common drugs such as narcotics, barbiturates, amphetamines, and salicylates.

(c) Program design includes efficient supporting recordkeeping and reporting measures within the communications network.

(d) Though this program shall at all times function as a unitary system of services to Arkansas medical and allied health professionals, it shall embrace three (3) permanent components:

(1) The College of Pharmacy of the University of Arkansas for Medical Sciences which is charged with emergency poison and drug information responsibility;

(2) The Library of the University of Arkansas for Medical Sciences which is charged with nonemergency poison and drug information responsibility; and

(3) The Chemistry Branch of the Public Health Laboratory of the Department of Health which is charged with the emergency toxicological laboratory services responsibility.

History. Acts 1975, No. 600, § 2; A.S.A. 1947, § 82-3502.

20-13-508. Designation of personnel.

(a) Each permanent component within the PC-DI-TL services system shall designate those persons within the component department who shall have responsibility for implementing and developing this toxicology services system, and each shall provide written notice of the designations to the Director of the Department of Health.

(b) The persons so designated shall be qualified by education, training, and experience to ensure the effectiveness of this subchapter.

History. Acts 1975, No. 600, § 6; A.S.A. 1947, § 82-3506.

20-13-509. Compensation for student workers.

(a) Subject to the approval of the Dean of the College of Pharmacy of the University of Arkansas for Medical Sciences, registration or tuition fees, or both, in the University of Arkansas system are to be waived for those students who provide concurrent services to the Arkansas Poison and Drug Information Center of the College of Pharmacy of the University of Arkansas for Medical Sciences.

(b) Any funds at the disposal of the College of Pharmacy of the University of Arkansas for Medical Sciences can be used to provide scholarships and fellowships to those providing services to the center.

History. Acts 1975, No. 600, § 6; 1983, No. 793, § 1; A.S.A. 1947, § 82-3506.

20-13-510. Personnel immunity.

None of the personnel within any of the components of the PC-DI-TL services system shall incur personal liability or be placed in any legal jeopardy for laboratory services provided, analyses executed and reported, information proffered in good faith, professional judgments and responses provided for the system, or any good faith professional efforts to effectuate the purposes of this subchapter.

History. Acts 1975, No. 600, § 8; A.S.A. 1947, § 82-3508.

20-13-511. Recordkeeping and reporting.

Each of the University of Arkansas for Medical Sciences components, the Arkansas Poison and Drug Information Center, the Library of the University of Arkansas for Medical Sciences for nonemergency poison and drug information, and the Chemistry Branch of the Public Health Laboratory of the Department of Health, shall make available to the Director of the Department of Health, in such manner, form, or at such times as he or she shall require, copies of records and reports regarding all activities authorized and developed pursuant to this subchapter.

History. Acts 1975, No. 600, § 5; A.S.A. 1947, § 82-3505.

SUBCHAPTER 6 — NERVE AGENTS EMERGENCY TREATMENT ACT

SECTION.

- 20-13-601. Title.
- 20-13-602. Purpose.
- 20-13-603. Definition.
- 20-13-604. Eligibility for certificate.

SECTION.

- 20-13-605. Authority of certificate holder.
- 20-13-606. Immunity.
- 20-13-607. Administration of subchapter.

Effective Dates. Acts 1991, No. 270, § 11: Feb. 28, 1991. Emergency clause provided: “It is hereby found and determined by the General Assembly of the State of Arkansas that it is necessary to provide for the emergency treatment of those persons who have a severe adverse reaction to nerve agents since stockpiles of

nerve agents do exist within the state of Arkansas. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health, and safety, shall be in full force and effect from and after its passage and approval.”

20-13-601. Title.

This subchapter shall be known and cited as the “Nerve Agents Emergency Treatment Act”.

History. Acts 1991, No. 270, § 1.

20-13-602. Purpose.

It is the purpose of this subchapter to provide a means of authorizing certain individuals to administer treatment to those persons who have severe adverse reactions to nerve agents when a physician is not immediately available.

History. Acts 1991, No. 270, § 2.

20-13-603. Definition.

As used in this subchapter, “physician” means a natural person licensed to practice medicine in the State of Arkansas pursuant to the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.

History. Acts 1991, No. 270, § 3.

20-13-604. Eligibility for certificate.

Persons eligible to receive a certificate pursuant to this subchapter shall meet the following requirements:

- (1) Be eighteen (18) years of age or older;
- (2) Have, or reasonably expect to have, responsibility for at least one (1) other person as a result of one’s relationship, or one’s occupational or volunteer status, for example, emergency medical technician, fire department personnel, P.H. nurses, etc.; and
- (3) Have been properly trained by a qualified instructor who has been certified by a physician licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq. The curriculum shall minimally include recognition of the symptoms of systemic reactions to nerve agents and the proper administration of an injection of atropine/pralidoxime, or other drugs as approved by the State Health Officer for the treatment of symptoms caused by exposure to nerve agents.

History. Acts 1991, No. 270, § 4.

20-13-605. Authority of certificate holder.

(a) A certificate issued pursuant to this subchapter shall authorize the holder thereof to receive upon presentation of the certificate, from any physician, a prescription for premeasured doses of atropine/pralidoxime, or other drugs as approved by the State Health Officer for the treatment of symptoms caused by exposure to nerve agents, and the necessary paraphernalia for administration.

(b) The certificate shall also authorize the holder thereof to possess and administer, in an emergency situation when a physician is not immediately available, the prescribed atropine/pralidoxime, or other drugs as approved by the State Health Officer for the treatment of symptoms caused by exposure to nerve agents, to persons suffering a severe adverse reaction to nerve agents.

(c) The holder may administer atropine/pralidoxime, or other drugs as approved by the State Health Officer, for the treatment of symptoms caused by exposure to nerve agents.

History. Acts 1991, No. 270, § 5.

20-13-606. Immunity.

No cause of action shall arise against a certificate holder pursuant to this subchapter or against the issuing physician for any act or omission when acting in good faith pursuant to the authority granted by this subchapter, except when the conduct amounts to gross negligence.

History. Acts 1991, No. 270, § 6.

20-13-607. Administration of subchapter.

(a) The Department of Health shall prepare the appropriate certificate form to be available to physicians upon request to accomplish the purposes of this subchapter.

(b) A copy of all certificates issued pursuant to this subchapter shall be forwarded by the issuing physician to the department to be maintained on file and subject to public inspection.

History. Acts 1991, No. 270, § 7.

SUBCHAPTER 7 — ARKANSAS POISON AND DRUG INFORMATION CENTER

SECTION.

- 20-13-701. Legislative findings.
 20-13-702. Creation — Purpose — Scholarships — Waiver of tuition services.
 20-13-703. Definitions.
 20-13-704. Certification as state poison control center — Liability.

SECTION.

- 20-13-705. Obtaining information through fraudulent representation.
 20-13-706. Director — Powers and duties.

A.C.R.C. Notes. Acts 1991, No. 796, § 9, transferred the poison control and drug information portions of the Poison Control-Drug Information — Toxicological Laboratory Services Unitary System (§ 20-13-501 et seq.) to the College of Pharmacy of the University of Arkansas for Medical Sciences. The toxicological laboratory services are to remain the responsibility of the Arkansas Department of Health.

Effective Dates. Acts 1991, No. 796, § 13: July 1, 1991. Emergency clause provided: "It is hereby found and determined by the Seventy-Eighth General Assembly that the public health and safety require that immediate steps be taken to insure immediate passage of this act to protect the citizens of this state from the danger posed by injudicious use of dangerous substances; that this act should become effective at the beginning of the next fiscal year and that unless this emergency clause is

adopted this act may not become effective until after that date. Therefore an emergency is hereby declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 1991."

Acts 1997, No. 250, § 258: Feb. 24, 1997. Emergency clause provided: "It is hereby found and determined by the General Assembly that Act 1211 of 1995 established the procedure for all state boards and commissions to follow regarding reimbursement of expenses and stipends for board members; that this act amends various sections of the Arkansas Code which are in conflict with the Act 1211 of 1995; and that until this cleanup act becomes effective conflicting laws will exist. Therefore an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become ef-

fective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor

may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

20-13-701. Legislative findings.

(a) The General Assembly finds and declares that, because of the inherent threat of human danger posed by injudicious use, or misuse, of dangerous substances, Arkansas citizens are in need of emergency poison and drug information services and that the public health and welfare require such services.

(b) The General Assembly further finds and declares that legislation is required to authorize and provide effective practical delivery of emergency poison and drug information services judgments and responses to physicians and allied health professionals who deliver healthcare services within this state and, if funds permit, to those citizens of this state who request such services.

History. Acts 1991, No. 796, § 1.

20-13-702. Creation — Purpose — Scholarships — Waiver of tuition services.

(a) There is created the Arkansas Poison and Drug Information Center within the College of Pharmacy of the University of Arkansas for Medical Sciences.

(b) The purpose of the center is to implement a statewide emergency poison and drug information program designed and structured to deliver reliable, accurate, qualified professional judgments and responses to requests for emergency poison and drug information data.

(c) Any funds at the disposal of the College of Pharmacy of the University of Arkansas for Medical Sciences can provide scholarships and fellowships to those providing services to the center.

(d) Subject to the approval of the Dean of the College of Pharmacy of the University of Arkansas for Medical Sciences, registration or tuition fees, or both, in the University of Arkansas system are to be waived for those students who provide concurrent services to the center.

History. Acts 1991, No. 796, §§ 3, 6.

20-13-703. Definitions.

As used in this subchapter:

(1) "Center" means the Arkansas Poison and Drug Information Center; and

(2) "Director" means the Director of the Arkansas Poison and Drug Information Center.

History. Acts 1991, No. 796, § 2.

20-13-704. Certification as state poison control center — Liability.

(a) The program of the Arkansas Poison and Drug Information Center shall be structured and designed, to the extent resources permit, to meet the criteria for certification as a state poison control center by the American Association of Poison Control Centers.

(b) None of the center personnel or its designees shall incur personal liability or be placed in any legal jeopardy for information proffered in good faith, professional judgments and responses provided for the system, or any good faith professional effort to effectuate the purposes of this subchapter.

History. Acts 1991, No. 796, §§ 5, 7.

20-13-705. Obtaining information through fraudulent representation.

Any individual who shall fraudulently represent himself or herself to be a person entitled to invoke the services of the Arkansas Poison and Drug Information Center when such is not the case and any person who attempts to obtain information later put to illegal use in any way shall upon conviction be guilty of a Class B misdemeanor.

History. Acts 1991, No. 796, § 8.

20-13-706. Director — Powers and duties.

(a) The Director of the Arkansas Poison and Drug Information Center shall serve at the pleasure of the Dean of the College of Pharmacy of the University of Arkansas for Medical Sciences.

(b) The director may:

(1) Employ any coordination measures necessary to effectuate the purposes of this subchapter;

(2) Engage in any educational program or effort if, in his or her judgment, such an activity would effectuate the purposes of this subchapter;

(3) Employ experts and consultants and compensate those individuals at rates determined by the director;

(4) Engage in programs of experimental or demonstrational research;

(5) Appoint an advisory committee to assist in the development and review of regulations promulgated under the authority of this subchapter and reimburse the members for their expenses in accordance with § 25-16-901 et seq.;

(6) Accept and administer loans, grants, or other funds and gifts, conditional or otherwise, from the United States Government and any other public or private sources;

- (7) Formulate, promulgate, adopt, amend, and enforce rules, regulations, and regulatory standards necessary to effectuate this subchapter;
- (8) Establish and charge fees for the provision of nonemergency informational and educational services, as well as contract therefor; and
- (9) Establish a “1-900” telephone number if funding otherwise precludes twenty-four-hour coverage consistent with requirements for certification by the American Association of Poison Control Centers.

History. Acts 1991, No. 796, §§ 3, 4; 1997, No. 250, § 184.

SUBCHAPTER 8 — TRAUMA SYSTEM ACT

SECTION.	SECTION.
20-13-801. Title.	20-13-812. Grants for Level III trauma centers.
20-13-802. Legislative findings.	20-13-813. Grants for Level IV trauma centers.
20-13-803. Definitions.	20-13-814. Grants for rehabilitation services.
20-13-804. Powers and duties of the Department of Health.	20-13-815. Contracts with quality improvement organizations.
20-13-805. Standards for verification of trauma center status.	20-13-816. Grants for trauma regional advisory councils.
20-13-806. Trauma data collection and evaluation system — Confidentiality of records.	20-13-817. Command and communication networks.
20-13-807. Trauma Advisory Council.	20-13-818. Injury prevention programs.
20-13-808. Terms — Vacancies — Meetings — Rules.	20-13-819. Quality or system assessment and improvement — Definition.
20-13-809. Grants for emergency medical system care providers or ambulance providers.	20-13-820. Reports to the General Assembly.
20-13-810. Grants for Level I trauma centers.	20-13-821. Rules.
20-13-811. Grants for Level II trauma centers.	

Effective Dates. Acts 2009, No. 393, § 2: July 1, 2009. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that the state incurs a massive expense from trauma in lives lost, productive years destroyed, and the emotional and monetary expense of caring for victims of trauma; that a coordinated and comprehensive system of trauma care has shown in other states to improve overall trauma problems; and that this act is immediately necessary because the current law must be amended to provide for a coordinated and comprehensive trauma system to ensure that all trauma victims have the greatest chance for survival and a reduced risk for permanently disabling injuries. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2009.”

20-13-801. Title.

This subchapter is known and may be cited as the “Trauma System Act”.

History. Acts 1993, No. 559, § 1; 2009, No. 393, § 1.

20-13-802. Legislative findings.

The General Assembly finds that:

(1) Traumatic injury is recognized as the leading killer of persons one (1) year to forty-four (44) years of age and is a serious yet preventable condition;

(2) Deaths due to trauma in the United States for 2005 were nearly one hundred thirty-nine thousand (139,000), and children nineteen (19) years of age or younger accounted for nearly twelve percent (12%) of the deaths;

(3) In 2006, two thousand one hundred nineteen (2,119) Arkansans lost their lives and twenty-five thousand three hundred eight (25,308) were admitted to hospitals due to trauma;

(4) The State of Arkansas incurs a massive expense from trauma in lives lost, productive years destroyed, and the emotional and monetary expense of caring for victims of trauma; and

(5) The experience of other states has shown that a comprehensive trauma system, including all phases of trauma care from prevention, prehospital care, and trauma center designation to rehabilitative care, can vastly improve overall trauma problems.

History. Acts 1993, No. 559, § 2; 2009, No. 393, § 1.

20-13-803. Definitions.

As used in this subchapter:

(1) “Department” means the Department of Health; and

(2) “EMS Division” means the Division of Emergency Medical Services of the Department of Health.

History. Acts 1993, No. 559, § 3; 2009, No. 393, § 1.

20-13-804. Powers and duties of the Department of Health.

(a) The Department of Health may develop and implement a comprehensive trauma care system that provides guidelines for the care of trauma victims and is fully integrated with all available resources, including, but not limited to, existing emergency medical services providers, hospitals, or other healthcare providers that would like to participate in the program.

(b)(1) The department shall allocate funds deposited into the Public Health Fund to administer this subchapter.

(2) Allocations of funds in the form of grants or contracts from the funds deposited into the Public Health Fund to administer this subchapter may include without limitation:

(A) Emergency medical system care providers and ambulance providers under § 20-13-809;

(B) Level I, Level II, Level III, and Level IV trauma centers under §§ 20-13-810 — 20-13-813;

(C) Rehabilitation service providers under § 20-13-814;

(D) Quality improvement organizations under § 20-13-815;

(E) Trauma regional advisory councils under § 20-13-816;

(F) Command and communication networks under § 20-13-817; and

(G) Injury prevention programs under § 20-13-818.

(c) The funds deposited into the Public Health Fund to administer this subchapter will be used to fund two (2) general types of grants with entities necessary to administer this subchapter:

(1) Start-up trauma grants to support initial costs required to qualify for participation in the trauma care system; and

(2) Sustaining trauma grants to support ongoing readiness costs for continued participation in the trauma care system.

(d) The department may contract with entities as necessary to implement this subchapter.

History. Acts 1993, No. 559, § 4; 2009, No. 393, § 1; 2017, No. 812, § 1.

A.C.R.C. Notes. Acts 2017, No. 812, § 4, provided: “Education requirements within the rules of the Department of Health regarding trauma systems. Until March 1, 2019, the Department of Health may either waive or substitute educational requirements within the rules regarding trauma systems to ensure that

hospitals retain their trauma level designation.”

Amendments. The 2017 amendment deleted former (b)(2) and redesignated former (b)(3) as present (b)(2); and substituted “without limitation” for “but are not limited to” at the end of the introductory language in present (b)(2).

Cross References. Public Health Fund, § 19-5-307.

20-13-805. Standards for verification of trauma center status.

(a) The State Board of Health may adopt standards for designation and verification of trauma center status which assign level designations based on resources available within the facility.

(b)(1) Standards shall be based upon national guidelines, including those established by the American College of Surgeons entitled “Resources for Optimal Care of the Injured Patient (6th edition)” and published appendices thereto.

(2) Standards specific to address the unique nature of Arkansas may be developed and modified by rule of the board.

History. Acts 1993, No. 559, § 5; 2009, No. 393, § 1.

20-13-806. Trauma data collection and evaluation system — Confidentiality of records.

(a)(1) The Department of Health shall develop a trauma data collection and evaluation system known as the “Trauma Registry”.

(2) The Trauma Registry shall be designed to study both the individual and collective care and treatment given to patients of the trauma system.

(b)(1) The department may collect data and information regarding patients treated and transported from the field and admitted to a facility through the emergency department, through a trauma center, or directly to a special care unit or post-hospitalization facility.

(2) Data and information shall be collected in a manner which protects and maintains the confidential nature of patient records.

(c) Records and reports made pursuant to this subchapter shall be held confidential within the hospital and department and shall not be available to the public.

(d) The department shall require all recipients of sustaining grants under this subchapter to participate in the state-specified Trauma Registry.

History. Acts 1993, No. 559, § 6; 2009, No. 393, § 1; 2013, No. 1132, § 7.

in (b)(1), deleted “as deemed necessary and appropriate” following “collect” and inserted “and” following “from the field”.

Amendments. The 2013 amendment,

20-13-807. Trauma Advisory Council.

(a) There is established an advisory council, to be known as the “Trauma Advisory Council”, for the purpose of making recommendations, advising, and providing assistance to the Department of Health concerning the development and operation of a statewide trauma system.

(b) The Trauma Advisory Council shall consist of twelve (12) voting members who have a demonstrated interest in trauma systems to be appointed by the Governor subject to confirmation by the Senate as follows:

(1) One (1) member appointed by the Governor after consulting the Arkansas Chapter of the American College of Emergency Physicians;

(2) One (1) member appointed by the Governor after consulting the Arkansas Chapter of the American College of Surgeons;

(3) One (1) member appointed by the Governor after consulting the Arkansas Medical Society, Inc.;

(4) Three (3) members appointed by the Governor after consulting the Arkansas Hospital Association, Inc.;

(5) One (1) member appointed by the Governor after consulting the Emergency Medical Services Advisory Council;

(6) One (1) member appointed by the Governor after consulting the Arkansas Emergency Medical Technicians Association;

(7) One (1) member appointed by the Governor after consulting The Arkansas Ambulance Association;

(8) One (1) member appointed by the Governor after consulting the Arkansas Minority Health Commission;

(9) One (1) member appointed to represent injury prevention; and

(10) One (1) member appointed from the public at large as a consumer representative who has an interest in trauma systems.

(c) The Trauma Advisory Council shall also include four (4) voting members who have a demonstrated interest in trauma systems to be appointed as follows:

(1) Two (2) members to be appointed by and to serve at the pleasure of the President Pro Tempore of the Senate after consulting the Arkansas Medical, Dental, and Pharmaceutical Association Inc. and the Arkansas Emergency Nurses Association; and

(2) Two (2) members to be appointed by and to serve at the pleasure of the Speaker of the House of Representatives after consulting the Arkansas Academy of Family Physicians.

(d) The Director of the Department of Health or his or her designee shall serve as a nonvoting ex officio member of the Trauma Advisory Council.

History. Acts 1993, No. 559, § 7; 1995, No. 981, § 1; 2001, No. 1288, § 16; 2009, No. 393, § 1; 2015, No. 1100, § 48; 2017, No. 812, § 2.

Amendments. The 2015 amendment inserted “subject to confirmation by the Senate” in the introductory language of (b); substituted “by the Governor after consulting” for “from a list of two (2) nominees submitted by” throughout (b); substituted “by the Governor after con-

sulting” for “from a list of eight (8) nominees submitted by” in (b)(5); and deleted “Governor’s” preceding “Emergency Medical” in (b)(6).

The 2017 amendment rewrote (b); added “after consulting the Arkansas Medical, Dental, and Pharmaceutical Association and the Arkansas Emergency Nurses Association” in (c)(1); added “after consulting the Arkansas Academy of Family Physicians” in (c)(2); and rewrote (d).

20-13-808. Terms — Vacancies — Meetings — Rules.

(a) All voting members of the Trauma Advisory Council shall be appointed for terms of five (5) years.

(b)(1) If a vacancy occurs in an appointed position for any reason, the vacancy shall be filled in the manner provided for the original appointment under § 20-13-807.

(2) The new appointee shall serve for the remainder of the unexpired term.

(c) A member of the council shall be removed for conviction of a felony, for not attending fifty percent (50%) of the meetings in a calendar year, or if the member no longer meets the qualifications for his or her initial appointment.

(d)(1) The members of the council shall elect from their membership a chair, a vice chair, and a secretary, whose duties shall be those customarily exercised by those officers or duties specifically designated by the council.

(2) All officers shall serve for a period of two (2) years and until their successors are elected.

(e)(1) A majority of the voting members of the council shall constitute a quorum for the purpose of transacting business.

(2) Except for actions taken pursuant to subsection (g) of this section, all actions of the council shall be made by a majority of all voting members.

(f) The council shall meet at least four (4) times a year but may meet more frequently upon the call of the Chair of the Trauma Advisory Council or at the request, stated in writing, of a majority of the members of the council.

(g)(1) To assist in the expeditious conduct of its business when the full council is not meeting, the council may elect an executive committee.

(2) The chair, the Vice Chair of the Trauma Advisory Council, and the Secretary of the Trauma Advisory Council shall be members of the executive committee.

(3) The executive committee shall be constituted and shall function as provided in the bylaws of the council.

(h) The council shall establish its own rules of procedure.

History. Acts 1993, No. 559, § 8; 2007, No. 827, § 157; 2009, No. 393, § 1; 2017, No. 540, § 43; 2017, No. 812, § 3.

Publisher's Notes. Acts 1993, No. 559, § 8, provided: "The first members of the council appointed by the Governor shall draw lots to determine their respective terms as follows:

"(A) Three (3) shall serve a term of four (4) years;

"(B) Three (3) shall serve a term of three (3) years;

"(C) Three (3) shall serve a term of two (2) years; and

"(D) Three (3) shall serve a term of one (1) year."

Amendments. The 2017 amendment by No. 540 substituted "five (5)" for "two (2)" in (a).

The 2017 amendment by No. 812 substituted "A majority" for "Thirteen (13)" in (e)(1).

20-13-809. Grants for emergency medical system care providers or ambulance providers.

An emergency medical system care provider or ambulance provider may be eligible for:

(1) The emergency medical system care provider education start-up grants that are used to support trauma education and trauma readiness; or

(2) The emergency medical system care provider sustaining grants that are used to support ongoing trauma education and trauma readiness.

History. Acts 2009, No. 393, § 1.

20-13-810. Grants for Level I trauma centers.

(a)(1) An entity that meets the preliminary criteria for a Level I trauma center under the rules of the State Board of Health may be eligible for the Level I trauma center start-up grant that is used to

qualify for the status of a Level I trauma center and for trauma readiness costs associated with the care of trauma patients.

(2) This grant may be awarded to entities that:

(A) Meet the preliminary criteria for Level I trauma center status as determined by the Department of Health; and

(B) Demonstrate the capability of fully achieving Level I trauma center status within eighteen (18) months.

(b)(1) An established Level I trauma center may be eligible for a sustaining grant if the Level I trauma center:

(A) Has achieved Level I trauma center status and is currently at Level I status; and

(B) Demonstrates continued capability to maintain Level I trauma center status.

(2) This grant may be an annual grant and may have an annual renewal process for Level I trauma centers that meet the criteria under this subsection.

History. Acts 2009, No. 393, § 1.

20-13-811. Grants for Level II trauma centers.

(a)(1) An entity that meets the preliminary criteria for a Level II trauma center under the rules of the State Board of Health may be eligible for the Level II trauma center start-up grant that is used to qualify for the status of a Level II trauma center and for trauma readiness costs associated with the care of trauma patients.

(2) This grant may be awarded to entities that:

(A) Meet the preliminary criteria for Level II trauma center status as determined by the Department of Health; and

(B) Demonstrate the capability of fully achieving Level II trauma center status within twelve (12) months.

(b)(1) An established Level II trauma center may be eligible for a sustaining grant if the Level II trauma center:

(A) Has achieved Level II trauma center status and is currently at Level II status; and

(B) Demonstrates continued capability to maintain Level II trauma center status.

(2) This grant may be an annual grant and may have an annual renewal process for Level II trauma centers that meet the criteria under this subsection.

History. Acts 2009, No. 393, § 1.

20-13-812. Grants for Level III trauma centers.

(a)(1) An entity that meets the preliminary criteria for a Level III trauma center under the rules of the State Board of Health may be eligible for the Level III trauma center start-up grant that is used to qualify for the status of a Level III trauma center and for trauma readiness costs associated with the care of trauma patients.

(2) This grant may be awarded to entities that:

(A) Meet the preliminary criteria for Level III trauma center status as determined by the Department of Health; and

(B) Demonstrate the capability of fully achieving Level III trauma center status within twelve (12) months.

(b)(1) An established Level III trauma center may be eligible for a sustaining grant if the Level III trauma center:

(A) Has achieved Level III trauma center status and is currently at Level III status; and

(B) Demonstrates continued capability to maintain Level III trauma center status.

(2) This grant may be an annual grant and may have an annual renewal process for Level III trauma centers that meet the criteria under this subsection.

History. Acts 2009, No. 393, § 1.

20-13-813. Grants for Level IV trauma centers.

(a)(1) An entity that meets the preliminary criteria for a Level IV trauma center under the rules of the State Board of Health may be eligible for the Level IV trauma center start-up grant that is used to qualify for the status of a Level IV trauma center and for trauma readiness costs associated with the care of trauma patients.

(2) This grant may be awarded to entities that:

(A) Meet the preliminary criteria for Level IV trauma center status as determined by the Department of Health; and

(B) Demonstrate the capability of fully achieving Level IV trauma center status within twelve (12) months.

(b)(1) An established Level IV trauma center may be eligible for a sustaining grant if the Level IV trauma center:

(A) Has achieved Level IV trauma center status and is currently at Level IV status; and

(B) Demonstrates continued capability to maintain Level IV trauma center status.

(2) This grant may be an annual grant and may have an annual renewal process for Level IV trauma centers that meet the criteria under this subsection.

History. Acts 2009, No. 393, § 1.

20-13-814. Grants for rehabilitation services.

Grants may be awarded to providers, entities, or organizations with special competence in trauma rehabilitation services that provide rehabilitation services under this subchapter to trauma patients.

History. Acts 2009, No. 393, § 1.

20-13-815. Contracts with quality improvement organizations.

(a) An entity that meets the preliminary criteria for a quality improvement organization under the rules of the State Board of Health may contract with the Department of Health to develop, promulgate, and measure trauma quality measures for entities providing care for the trauma system under this subchapter.

(b) This contract may be awarded to entities that:

(1) Meet the preliminary criteria for a quality improvement organization as determined by the Department of Health; and

(2) Demonstrate the capability of providing to the trauma system, trauma centers, and other trauma care providers:

(A) The development of quality measures;

(B) The implementation of educational programs to trauma care providers related to quality measures and to improve the quality of care; and

(C) The gathering of data that can be used to measure the quality of care, outcomes, and utilization of resources.

History. Acts 2009, No. 393, § 1.

20-13-816. Grants for trauma regional advisory councils.

(a)(1) An entity that meets the preliminary criteria for a trauma regional advisory council under the rules of the State Board of Health may be eligible for recognition as a trauma regional advisory council.

(2) The Department of Health may establish a grant or provide technical assistance to entities that:

(A) Meet the preliminary criteria for a trauma regional advisory council as determined by the Department of Health; and

(B) Demonstrate the capability of satisfactorily developing, overseeing, and administering the trauma system plan for its region.

(b)(1) An established trauma regional advisory council may be eligible for a sustaining grant if the trauma regional advisory council:

(A) Has achieved the status as the trauma regional advisory council for its region of the trauma system and is currently providing trauma planning and quality improvement services to its region of the trauma system; and

(B) Demonstrates continued capability to maintain its status as a trauma regional advisory council based on its performance in planning and overseeing the plan for its region of the trauma system.

(2) This grant may be an annual grant and have an annual renewal process for a trauma regional advisory council that meets the criteria under this subsection.

History. Acts 2009, No. 393, § 1.

20-13-817. Command and communication networks.

(a) The Department of Health shall ensure operation of a call center to facilitate communication and coordination of available resources.

(b) The call center shall direct patient transport of critical trauma patients to hospitals with the appropriate capability to provide optimum patient care.

(c) The department may contract with entities to provide command and communication networks.

History. Acts 2009, No. 393, § 1.

20-13-818. Injury prevention programs.

The Department of Health shall allocate funds to develop and promote injury prevention programs including the development of the capacity to track and describe the epidemiologic and health statistics of injury deaths and disabilities in Arkansas.

History. Acts 2009, No. 393, § 1.

20-13-819. Quality or system assessment and improvement — Definition.

(a)(1) Any data, records, reports, and documents collected or compiled by or on behalf of the Department of Health, the Trauma Advisory Council, or other entity authorized under this subchapter for the purpose of quality or system assessment and improvement of the trauma system shall not be subject to disclosure under the Freedom of Information Act of 1967, § 25-19-101 et seq., to the extent that it identifies or could be used to identify any individual patient, provider, institution, or health plan.

(2) For purposes of this section, “data, records, reports, and documents” means recordings of interviews and all oral or written proceedings, reports, statements, minutes, memoranda, data, and other documentation collected or compiled for the purposes of trauma system quality review or trauma system assessment and improvement pursuant to a requirement of or request by the department, the council, or other entity authorized by this subchapter.

(b)(1) Any data, records, reports, and documents collected or compiled by or on behalf of the department, the council, or other entity authorized under this subchapter for the purpose of quality or system assessment and improvement shall not be admissible in any legal proceeding and shall be exempt from discovery and disclosure to the same extent that records of and testimony before committees evaluating the quality of medical or hospital care are exempt under § 16-46-105(a)(1).

(2) A healthcare provider’s use of the information in its internal operations shall not operate as a waiver of these protections.

(c) All information shall be treated in a manner that is consistent with all state and federal privacy requirements, including without

limitation the federal Health Insurance Portability and Accountability Act of 1996 privacy rule, 45 C.F.R. § 164.512(i).

(d) The department or other entity authorized to provide services for the trauma system may use any data, records, reports, or documents generated or acquired in its internal operations without waiving any protections under this section.

History. Acts 2009, No. 393, § 1.

20-13-820. Reports to the General Assembly.

The Director of the Department of Health shall provide a report to the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare, and Labor on or before April 1 and October 1 of each year through 2011. After 2011, the director shall provide an annual report to the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare, and Labor on or before October 1.

History. Acts 2009, No. 393, § 1.

20-13-821. Rules.

The State Board of Health shall promulgate the rules necessary to implement and administer this subchapter.

History. Acts 2009, No. 393, § 1.

SUBCHAPTER 9 — ARKANSAS EMERGENCY MEDICAL SERVICES DO NOT RESUSCITATE ACT

SECTION.	SECTION.
20-13-901. Definitions.	20-13-905. Patient’s decision — Effect on insurance.
20-13-902. Immunities.	20-13-906. Rulemaking authority.
20-13-903. Authorization to follow Emergency Medical Services Do Not Resuscitate Orders in the prehospital setting.	20-13-907. Reciprocity.
20-13-904. Adherence to Do Not Resuscitate Protocol — Transfer of patients.	20-13-908. Penalties.

20-13-901. Definitions.

As used in this subchapter:

- (1) “Attending physician” has the meaning provided in § 20-17-201;
- (2) “Board” means the State Board of Health;
- (3) “Department” means the Department of Health;
- (4) “Do Not Resuscitate Identification” means a standardized identification card, form, necklace, or bracelet of uniform size and design, approved by the department, that signifies:

(A) That the possessor has executed an advance directive as provided in § 20-17-202 which specifically addresses the cardiopulmonary resuscitation option of health care and which has not been revoked; or

(B) That the possessor's attending physician has issued an Emergency Medical Services Do Not Resuscitate Order for the possessor and has documented the grounds for the order in the possessor's medical file;

(5)(A) "Emergency Medical Services Do Not Resuscitate Order" means a written physician's order in a form approved by the department which authorizes qualified emergency medical services personnel to withhold cardiopulmonary resuscitation from a particular patient in the event of cardiac or respiratory arrest.

(B) For the purposes of this subchapter, "cardiopulmonary resuscitation" or "CPR" shall include cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications, and related procedures.

(C)(i) Emergency Medical Services Do Not Resuscitate Orders shall not authorize the withholding of other medical interventions such as intravenous fluids, oxygen, nutrition or hydration, or both, or other indicated therapies short of cardiopulmonary resuscitation unless the therapies are also specified by advance directive or durable power of attorney for health care to be withheld.

(ii) The Emergency Medical Services Do Not Resuscitate Orders shall not authorize the withholding of therapies deemed necessary to provide comfort care or alleviate pain;

(6) "Emergency Medical Services Do Not Resuscitate Protocol" means a standardized method of procedure, approved by the board and adopted in the rules of the department, for the withholding of emergency life-sustaining procedures by emergency medical services personnel;

(7) "Emergency medical services personnel" means paid or volunteer firefighters, law enforcement officers, first responders, emergency medical technicians, or other emergency service personnel acting within the ordinary course of their professions;

(8)(A) "Healthcare facility" means any institution, building, or agency or portion thereof, private or public, excluding federal facilities, whether organized for profit or not, used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any person or persons.

(B) "Healthcare facility" includes, but is not limited to, ambulatory surgical facilities, health maintenance organizations, home health agencies, hospices, hospitals, infirmaries, kidney treatment centers, long-term care facilities, medical assistance facilities, mental health centers, outpatient facilities, public health centers, rehabilitation facilities, residential treatment facilities, and adult day care centers;

(9) "Life-sustaining procedure" means cardiopulmonary resuscitation or a component of cardiopulmonary resuscitation; and

(10) "Physician" means a person licensed to practice medicine in this state pursuant to the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.

History. Acts 1993, No. 1101, § 1; 2003, No. 1322, § 2.

A.C.R.C. Notes. Acts 2003, No. 1322, § 6, provided: "Legislative purpose.

"(a)(1) The General Assembly recognizes that residents of long-term care facilities are among the most vulnerable of the state's citizens.

"(2) Further, the disproportionate number of these residents who are Medicaid

eligible, and who have little or no close family involvement in their lives, heightens their vulnerability.

"(b) It is the intent of the General Assembly that, to ensure proper care and treatment of these individuals, particularly at end-of-life, the circumstances and conditions under which the withholding of nutrition, hydration, or both, may occur, be clarified."

20-13-902. Immunities.

(a) The following are not subject to civil or criminal liability and are not guilty of unprofessional conduct upon discovery of Do Not Resuscitate Identification upon a person:

(1) A physician who causes the withholding or withdrawal of life-sustaining procedures from that person;

(2) A person who participates in the withholding or withdrawal of life-sustaining procedures under the direction or with the authorization of a physician;

(3) Emergency medical services personnel who cause or participate in the withholding or withdrawal of life-sustaining procedures from that person;

(4) A healthcare facility in which withholding or withdrawal of life-sustaining procedures from that person occurs; and

(5) Physicians, persons under the direction or authorization of a physician, emergency medical services personnel, or healthcare facilities that provide life-sustaining procedures pursuant to an oral or written request communicated to them by a person who possesses Do Not Resuscitate Identification.

(b) The provisions of subdivisions (a)(1)-(5) of this section apply when a life-sustaining procedure is withheld or withdrawn in accordance with the Emergency Medical Services Do Not Resuscitate Protocol.

(c) Emergency medical services personnel who follow a Do Not Resuscitate Order from a licensed physician are not subject to civil or criminal liability and are not guilty of unprofessional conduct.

History. Acts 1993, No. 1101, § 2.

20-13-903. Authorization to follow Emergency Medical Services Do Not Resuscitate Orders in the prehospital setting.

(a) Qualified emergency medical services personnel may follow Emergency Medical Services Do Not Resuscitate Orders pertaining to adult patients in the prehospital setting in accordance with regulations

promulgated by the State Board of Health, if the order available to the personnel is in a format approved by the Department of Health.

(b) This section shall not authorize emergency medical personnel to follow an Emergency Medical Services Do Not Resuscitate Order for any patient who is able to and does express to the personnel the desire to be resuscitated before cardiac or respiratory arrest.

History. Acts 1993, No. 1101, § 3.

20-13-904. Adherence to Do Not Resuscitate Protocol — Transfer of patients.

(a) Emergency medical services personnel other than physicians shall comply with the Do Not Resuscitate Protocol when presented with either Do Not Resuscitate Identification approved by the Department of Health, an oral Do Not Resuscitate Order issued directly by a physician, or a written Do Not Resuscitate Order entered on a form prescribed by the department.

(b) An attending physician or a healthcare facility that receives a patient from emergency medical services with a valid Do Not Resuscitate Identification which the patient or his or her healthcare proxy does not remand by written or oral statement and that is unwilling or unable to comply with a Do Not Resuscitate Order shall take all reasonable steps to transfer that person possessing Do Not Resuscitate Identification to another physician or to a healthcare facility in which the Do Not Resuscitate Order will be followed.

History. Acts 1993, No. 1101, § 4.

20-13-905. Patient's decision — Effect on insurance.

(a) Death resulting from the withholding or withdrawal of emergency life-sustaining procedures pursuant to the Do Not Resuscitate Protocol and in accordance with this subchapter is not for any purpose a suicide or homicide.

(b) The possession of Do Not Resuscitate Identification pursuant to this subchapter does not affect in any manner the sale, procurement, or issuance of any policy of life insurance nor does it modify the terms of an existing policy of life insurance. A policy of life insurance is not legally impaired or invalidated in any manner by the withholding or withdrawal of emergency life-sustaining procedures from an insured person possessing Do Not Resuscitate Identification, notwithstanding any term of the policy to the contrary.

(c) A physician, healthcare facility, or other healthcare provider and a healthcare service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital plan may not require a person to possess Do Not Resuscitate Identification as a condition for being insured for or receiving healthcare services.

(d) This subchapter does not create a presumption concerning the intention of an individual who does not possess Do Not Resuscitate

Identification with respect to the use, withholding, or withdrawal of emergency life-sustaining procedures.

(e) This subchapter does not increase or decrease the right of a patient to make decisions regarding the use of emergency life-sustaining procedures if the patient is able to do so nor does this subchapter impair or supersede any right or responsibility that a person has to effect the withholding or withdrawal of medical care in any lawful manner. In that respect, the provisions of this subchapter are cumulative.

(f) This subchapter does not authorize or approve mercy killing.

History. Acts 1993, No. 1101, § 5.

20-13-906. Rulemaking authority.

(a) Upon the adoption of an Emergency Medical Services Do Not Resuscitate Protocol by the State Board of Health, the Department of Health may adopt a standard form of Do Not Resuscitate Identification to be used statewide.

(b) The department shall adopt rules to administer the provisions of this subchapter.

History. Acts 1993, No. 1101, § 6.

20-13-907. Reciprocity.

(a) An advance directive executed in another state shall be deemed to be validly executed for the purposes of this subchapter if executed in compliance with the laws of the State of Arkansas or the laws of the state where executed.

(b) Such advance directives shall be construed in accordance with the laws of the State of Arkansas.

History. Acts 1993, No. 1101, § 7.

20-13-908. Penalties.

(a) A physician who willfully fails to transfer a patient in accordance with § 20-13-904 is guilty of a Class A misdemeanor.

(b) A person who purposely conceals, cancels, defaces, or obliterates the Do Not Resuscitate Identification of another without the consent of the possessor or who falsifies or forges a revocation of the Do Not Resuscitate Identification of another is guilty of a Class A misdemeanor.

(c) A person who falsifies or forges the Do Not Resuscitate Identification of another or purposely conceals or withholds personal knowledge of a revocation of Do Not Resuscitate Identification with the intent to cause the use, withholding, or withdrawal of life-sustaining procedures is guilty of a Class D felony.

History. Acts 1993, No. 1101, § 8.

SUBCHAPTER 10 — AMBULANCE SERVICES

SECTION.

- 20-13-1001. License required.
20-13-1002. License application and renewal.
20-13-1003. Choice-of-care facility — Reporting requirements — Insurance coverage.

SECTION.

- 20-13-1004. Advertising restrictions — Service area.
20-13-1005. Revocation of license.
20-13-1006. Regulation of mass casualty incidents.

20-13-1001. License required.

(a) No person shall furnish, operate, maintain, conduct, advertise, or in any way engage in or profess to engage in the business of providing emergency transport of patients upon the streets and highways of Arkansas unless that person holds a valid ambulance service license or provisional ambulance service license issued by the Department of Health.

(b) This section shall not operate to alter the application of the “Good Samaritan Law”, § 17-95-101.

History. Acts 1997, No. 1255, § 1.

20-13-1002. License application and renewal.

(a)(1) An application for the issuance or renewal of an ambulance service license or a provisional ambulance service license shall be made on forms provided by the Department of Health and shall be accompanied by any fee as required by law or by regulations promulgated by the department.

(2) Each license shall be renewed annually.

(b) Each licensee shall be issued a service license in one (1) of the classifications set forth by the department.

(c) The department shall promulgate regulations for the licensure and renewal of an ambulance service license.

History. Acts 1997, No. 1255, § 2.

20-13-1003. Choice-of-care facility — Reporting requirements — Insurance coverage.

(a)(1)(A) A licensee under this subchapter may transport any patient to the care facility of the patient’s choice subject to service area limitations, applicable federal law, and the licensee’s local protocol.

(B) If the patient is unable to make a choice and if the attending physician is present and has expressed a choice of care facility, the licensee may comply with the attending physician’s choice subject to service area limitations and applicable federal law.

(C) If the patient is unable to make a choice and the attending physician is not present or has not expressed a choice of facility, the licensee may, subject to applicable federal law, transport the patient to the nearest appropriate care facility.

(2) The licensee shall provide the care facility where the patient was transported with a copy of an ambulance service encounter form prescribed by the Department of Health, which shall become a part of the patient's medical records.

(b) Each licensee shall report in a format approved by the department every request that results in the dispatch of a vehicle.

(c)(1) Each licensee shall have in force and effect liability insurance coverage issued by an insurance company licensed to do business in the State of Arkansas for each vehicle owned and operated by or for the applicant or licensee.

(2) The department shall maintain evidence of proof of current liability insurance coverage for each vehicle of each licensee.

History. Acts 1997, No. 1255, § 3; 2009, No. 553, § 1; 2013, No. 1132, § 8.

Amendments. The 2013 amendment, in (a)(1)(A), substituted "subject to" for "if the licensee considers" and deleted "and subject to" preceding "applicable"; in (a)(1)(B), substituted "choice of care" for "choice-of-care" and "subject to" for "if the licensee considers" and deleted "subject to" following "area limitations and"; and in (a)(1)(C), inserted "subject to applicable federal law" and deleted "and subject to applicable federal law" following "care facility".

20-13-1004. Advertising restrictions — Service area.

(a) An ambulance service shall not in any way advertise to the general public the service areas, skills, procedures, or personnel certification levels which it cannot provide on every emergency request, twenty-four (24) hours a day, seven (7) days a week.

(b) The service area shall be clearly identified in writing and shall be on file with the Department of Health.

History. Acts 1997, No. 1255, § 5.

20-13-1005. Revocation of license.

Three (3) formal citations during the license term for failure to comply with this subchapter and any regulations promulgated by the Department of Health in regard to ambulance services shall result in revocation of the ambulance service license.

History. Acts 1997, No. 1255, § 4.

20-13-1006. Regulation of mass casualty incidents.

In mass casualty incidents, which overwhelm the region's available resources, the Department of Health shall promulgate regulations which establish procedures for the transportation of patients by ambulances.

History. Acts 1997, No. 1255, § 6.

SUBCHAPTER 11 — CRIMINAL RECORDS CHECK

SECTION.

- 20-13-1101. Definitions.
- 20-13-1102. Mandatory criminal history checks for emergency medical services personnel.
- 20-13-1103. [Repealed.]
- 20-13-1104. Form — State and national criminal history check.
- 20-13-1105. Response — File copies.
- 20-13-1106. Disqualifying offenses — Waiver.

SECTION.

- 20-13-1107. Procedure for challenge.
- 20-13-1108. Additional checks.
- 20-13-1109. Report and index — Forms — Database.
- 20-13-1110. Refusal of check as grounds for disqualification.
- 20-13-1111. Notice of convictions.
- 20-13-1112. Forms — Regulations.
- 20-13-1113. Confidentiality.
- 20-13-1114. Immunity.
- 20-13-1115. Applicability of subchapter.

Effective Dates. Acts 1999, No. 666, § 14: Mar. 17, 1999. Emergency clause provided: "It is hereby found and determined by the Eighty-second General Assembly, that sometimes persons providing care in the prehospital environment have criminal histories that impair their ability to provide adequate care; that injuries inflicted by these caretakers in positions of trust are devastating to the sense of well-being in our communities; and that it is crucial to the health, safety, and welfare of the citizens of the State of Arkansas that a criminal history check be conducted on all persons providing care in the prehospital environment so that those persons who are a danger can be identified. Therefore, an emergency is declared to exist and this Act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved

nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 2003, No. 1473, § 74: July 1, 2003. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that this act includes technical corrects to Act 923 of 2003 which establishes the classification and compensation levels of state employees covered by the provisions of the Uniform Classification and Compensation Act; that Act 923 of 2003 will become effective on July 1, 2003; and that to avoid confusion this act must also effective on July 1, 2003. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2003."

20-13-1101. Definitions.

As used in this subchapter:

- (1) "Applicant" means any individual seeking Arkansas emergency medical services personnel licensure or relicensure;
- (2) "Bureau" means the Identification Bureau of the Department of Arkansas State Police;
- (3) "Care" means treatment, services, assistance, education, training, instruction, or supervision in the prehospital emergency medical systems environment;

(4) “Division of Emergency Medical Services” means the organization within the Department of Health responsible for the enforcement of emergency medical services legislation within the State of Arkansas;

(5) “Emergency medical services personnel” means the individual who has been licensed as an EMT, Advanced EMT, or paramedic and who may perform those services equivalent to level of licensure;

(6) “Emergency medical services system” means the transportation and medical care provided to the ill or injured before arrival at a medical facility by a licensed emergency medical services personnel or other healthcare provider and the continuation of the initial emergency care within a medical facility subject to the approval of the medical staff and governing board of that facility;

(7) “Index” means the database maintained by the Identification Bureau of the Department of Arkansas State Police of criminal records checks that have been conducted on applicants for emergency medical services personnel licensure and relicensure;

(8) “Licensing agency” means the government agency charged with licensing the qualified individual to provide prehospital care;

(9) “Licensure” means the official acknowledgment by the Department of Health that an individual has demonstrated competence to perform the emergency medical services required for licensure under the rules, regulations, and standards adopted by the State Board of Health upon recommendation by the Emergency Medical Services Advisory Council;

(10) “National criminal history check” means a review of national criminal records maintained by the Federal Bureau of Investigation based on fingerprint identification or other positive identification methods;

(11) “Relicensure” means the official acknowledgment by the division that an individual has demonstrated competence to perform the emergency medical services required for relicensure under Arkansas EMS Rules and Regulations;

(12) “Report” means a statement of the criminal history of an applicant issued by the bureau; and

(13) “State criminal history check” means a review of state criminal records conducted by the bureau using the Arkansas Crime Information Center.

History. Acts 1999, No. 666, § 1; 2009, No. 689, § 13; 2013, No. 1132, § 9.

Amendments. The 2013 amendment

substituted “Identification Bureau of the Department of Arkansas State Police” for “bureau” in (7).

20-13-1102. Mandatory criminal history checks for emergency medical services personnel.

(a)(1) Any applicant applying for initial licensure shall complete a criminal history check form and shall request the Identification Bureau of the Department of Arkansas State Police to conduct a state or national criminal history check, or both, on the applicant.

(2) The applicant shall pay all appropriate fees for the state or national criminal history check, or both, as set forth by the bureau.

(3) The applicant shall attach the criminal history check form to the Arkansas emergency medical services personnel licensure application.

(b) The Division of Emergency Medical Services of the Department of Health shall conduct a state or national criminal history check, or both, on the applicant and determine whether the applicant is disqualified from licensure based on the report of the applicant's criminal history and forward its determination to the applicant directly.

History. Acts 1999, No. 666, § 2; 2009, No. 689, § 14; 2011, No. 627, § 1; 2013, No. 1132, § 10.

Amendments. The 2013 amendment,

in (b), substituted "Emergency Medical Services" for "EMS and Trauma Systems" and "licensure" for "certification".

20-13-1103. [Repealed.]

Publisher's Notes. This section, concerning application, fee, and determination of disqualification, was repealed by

Acts 2011, No. 627, § 1. The section was derived from Acts 1999, No. 666, § 2; 2009, No. 689, § 15.

20-13-1104. Form — State and national criminal history check.

(a) A request for a state or national criminal history check, or both, on a person shall include a completed form as required by the Identification Bureau of the Department of Arkansas State Police.

(b) If an applicant is requesting initial Arkansas emergency medical services personnel licensure and can provide proof of continuous residency in the State of Arkansas for the past five (5) years, then the applicant shall be required to have only a state criminal history check completed.

(c) If an applicant is requesting initial Arkansas emergency medical services personnel licensure and is from another state or if the applicant cannot provide proof of continuous residency in the State of Arkansas for the past five (5) years, the applicant shall be required to have both a state and a national criminal history check completed.

History. Acts 1999, No. 666, §§ 2, 5; 2009, No. 689, § 16; 2011, No. 627, § 1.

20-13-1105. Response — File copies.

The Division of Emergency Medical Services of the Department of Health shall maintain on file for a period of three (3) years, subject to inspection by the Arkansas Crime Information Center or the Identification Bureau of the Department of Arkansas State Police, a copy of each criminal history check completed by all applicants requesting state licensure.

History. Acts 1999, No. 666, §§ 3, 6; 2011, No. 627, § 1; 2013, No. 1132, § 11.

Amendments. The 2013 amendment substituted "Emergency Medical Ser-

vices" for "EMS and Trauma Systems" and "licensure" for "certification".

20-13-1106. Disqualifying offenses — Waiver.

(a) Except as provided in subdivision (e)(1) of this section, the Division of Emergency Medical Services of the Department of Health shall issue a determination that a person is disqualified from certification or recertification if the person has been found guilty of or has pleaded guilty or nolo contendere to any of the offenses listed in subsection (b) of this section, including offenses for which the record has been expunged. However, the Division of Emergency Medical Services shall forward a request for a waiver to the Director of the Department of Health on all applicants who have been convicted of the crimes listed in subsection (b) of this section if five (5) years have passed since the conviction, if five (5) years have passed since release from custodial confinement, or if the applicants are currently certified emergency medical technicians, before making the final determination on certification or recertification. These individuals will not be suspended before the director's making the final determination.

- (b)(1) Capital murder as prohibited in § 5-10-101;
- (2) Murder in the first degree as prohibited in § 5-10-102 and murder in the second degree as prohibited in § 5-10-103;
- (3) Manslaughter as prohibited in § 5-10-104;
- (4) Negligent homicide as prohibited in § 5-10-105;
- (5) Kidnapping as prohibited in § 5-11-102;
- (6) False imprisonment in the first degree as prohibited in § 5-11-103;
- (7) Permanent detention or restraint as prohibited in § 5-11-106;
- (8) Robbery as prohibited in § 5-12-102;
- (9) Aggravated robbery as prohibited in § 5-12-103;
- (10) Battery in the first degree as prohibited in § 5-13-201;
- (11) Aggravated assault as prohibited in § 5-13-204;
- (12) Introduction of controlled substance into the body of another person as prohibited in § 5-13-210;
- (13) Terroristic threatening in the first degree as prohibited in § 5-13-301(a);
- (14) Rape as prohibited in § 5-14-103;
- (15) Sexual indecency with a child as prohibited in § 5-14-110;
- (16) Sexual assault in the first degree, second degree, third degree, and fourth degree as prohibited in §§ 5-14-124 — 5-14-127;
- (17) Incest as prohibited in § 5-26-202;
- (18) Offenses against the family as prohibited in §§ 5-26-303 — 5-26-306;
- (19) Endangering the welfare of an incompetent person in the first degree as prohibited in § 5-27-201;
- (20) Endangering the welfare of a minor in the first degree as prohibited in § 5-27-205;
- (21) Permitting child abuse as prohibited in § 5-27-221(a);

(22) Engaging children in sexually explicit conduct for use in visual or print media, transportation of minors for prohibited sexual conduct, pandering or possessing visual or print medium depicting sexually explicit conduct involving a child, or use of a child or consent to use of a child in a sexual performance by producing, directing, or promoting a sexual performance by a child as prohibited in §§ 5-27-303 — 5-27-305, 5-27-402, and 5-27-403;

(23) Felony adult abuse as prohibited in § 5-28-103;

(24) Theft of property as prohibited in § 5-36-103;

(25) Theft by receiving as prohibited in § 5-36-106;

(26) Arson as prohibited in § 5-38-301;

(27) Burglary as prohibited in § 5-39-201;

(28) Felony violation of the Uniform Controlled Substances Act, § 5-64-101 et seq., as prohibited in:

(A) The former § 5-64-401; and

(B) Sections 5-64-419 — 5-64-442;

(29) Promotion of prostitution in the first degree as prohibited in § 5-70-104;

(30) Stalking as prohibited in § 5-71-229;

(31) Criminal attempt, criminal complicity, criminal solicitation, or criminal conspiracy as prohibited in §§ 5-3-201, 5-3-202, 5-3-301, and 5-3-401 to commit any of the offenses listed in this subsection;

(32) Driving or boating while intoxicated, § 5-65-103, that is a:

(A) Felony; and

(B) Fourth or subsequent offense;

(33) Computer child pornography as prohibited in § 5-27-603;

(34) Computer exploitation of a child in the first degree as prohibited in § 5-27-605;

(35) Aggravated assault upon a law enforcement officer or an employee of a correctional facility, § 5-13-211, if a Class Y felony; and

(36) Sexual extortion, § 5-14-113.

(c) An applicant shall not be disqualified from certification or recertification when the applicant has been found guilty of or has pleaded guilty or nolo contendere to a misdemeanor if the offense:

(1) Did not involve exploitation of an adult, abuse of a person, neglect of a person, or sexual contact; or

(2) Was not committed while performing the duties of an emergency medical technician.

(d)(1) The provisions of this section may be waived by the Department of Health upon written request by the person who is the subject of the criminal history check.

(2) The written request for waiver shall be mailed to the director within fifteen (15) calendar days after receipt of the determination by the Department of Health.

(3) Factors to be considered before granting a waiver shall include, but not be limited to:

(A) The age at which the crime was committed;

(B) The circumstances surrounding the crime;

(C) The length of time since the adjudication of guilt;

(D) The person's subsequent work history;

(E) The person's employment references;

(F) The person's character references; and

(G) Any other evidence demonstrating that the person does not pose a threat to the health or safety of persons to be cared for.

(e)(1) For purposes of this section, an expunged record of a conviction or plea of guilty or nolo contendere to an offense listed in subsection (b) of this section shall not be considered a conviction, guilty plea, or nolo contendere plea to the offense unless the offense is also listed in subdivision (e)(2) of this section.

(2) Because of the serious nature of the offenses and the close relationship to the type of work that is to be performed, the following shall result in permanent disqualification:

(A) Capital murder as prohibited in § 5-10-101;

(B) Murder in the first degree as prohibited in § 5-10-102 and murder in the second degree as prohibited in § 5-10-103;

(C) Kidnapping as prohibited in § 5-11-102;

(D) Rape as prohibited in § 5-14-103;

(E) Sexual assault in the first degree as prohibited in § 5-14-124 and sexual assault in the second degree as prohibited in § 5-14-125;

(F) Endangering the welfare of a minor in the first degree as prohibited in § 5-27-205 and endangering the welfare of a minor in the second degree as prohibited in § 5-27-206;

(G) Incest as prohibited in § 5-26-202;

(H) Arson as prohibited in § 5-38-301;

(I) Endangering the welfare of an incompetent person in the first degree as prohibited in § 5-27-201;

(J) Adult abuse that constitutes a felony as prohibited in § 5-28-103;

(K) Aggravated assault upon a law enforcement officer or an employee of a correctional facility, § 5-13-211, if a Class Y felony; and

(L) Sexual extortion, § 5-14-113.

History. Acts 1999, No. 666, § 4; 2003, No. 1087, § 18; 2003, No. 1383, § 1; 2003, No. 1473, § 39; 2005, No. 1773, §§ 1, 2; 2005, No. 1923, § 5; 2011, No. 570, § 125; 2015, No. 299, § 30; 2017, No. 367, §§ 23, 24; 2017, No. 664, §§ 17, 18.

A.C.R.C. Notes. Acts 2011, No. 570, § 1, provided: "Legislative intent. The intent of this act is to implement comprehensive measures designed to reduce recidivism, hold offenders accountable, and contain correction costs."

Amendments. The 2015 amendment

substituted "Driving or boating while intoxicated, § 5-65-103, that is a" for "Fourth or subsequent driving while intoxicated violations that constitute felony offenses under § 5-65-111(b)(3) and (4)" in (b)(32); and added (b)(32)(A) and (b)(32)(B).

The 2017 amendment by No. 367 added (b)(35) and (e)(2)(K).

The 2017 amendment by No. 664 added (b)(35) [now (b)(36)] and added (e)(2)(K) [now (e)(2)(L)].

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of sembly, Criminal Law, Computer Crimes,
Legislation, 2003 Arkansas General As- 26 U. Ark. Little Rock L. Rev. 361.

20-13-1107. Procedure for challenge.

(a) A person may challenge the completeness or accuracy of criminal history information pursuant to § 12-12-1013.

(b) The Division of Emergency Medical Services of the Department of Health shall follow the established procedures for applicants to challenge determinations in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq., as stated in the current EMS Rules and Regulations.

History. Acts 1999, No. 666, § 7.

20-13-1108. Additional checks.

The Division of Emergency Medical Services of the Department of Health maintains the right to conduct additional criminal history checks at the cost of the division on applicants or Arkansas-licensed emergency medical services personnel under investigation for violation of current emergency medical services laws or rules.

History. Acts 1999, No. 666, § 3; 2009,
No. 689, § 17.

20-13-1109. Report and index — Forms — Database.

(a) The Identification Bureau of the Department of Arkansas State Police shall maintain an index of the results of each applicant's criminal history check.

(b) The Division of Emergency Medical Services of the Department of Health shall develop forms that are approved by the bureau to be used for criminal history checks conducted under this subchapter.

(c) The division shall develop and maintain a database of determinations regarding applicants.

History. Acts 1999, No. 666, § 6; 2011,
No. 627, § 2.

20-13-1110. Refusal of check as grounds for disqualification.

(a) If an applicant fails or refuses to cooperate in obtaining criminal history checks, such circumstances shall be grounds to deny or revoke the applicant's certification.

(b) Any applicant failing to comply with this subchapter shall be denied certification or recertification until such time compliance is made with this subchapter.

History. Acts 1999, No. 666, §§ 4, 7.

20-13-1111. Notice of convictions.

Arkansas-licensed emergency medical services personnel shall notify the Division of Emergency Medical Services of the Department of Health of any conviction of or plea of guilty or nolo contendere to any offenses listed in § 20-13-1106(b) within ten (10) calendar days after the conviction or guilty plea or plea of nolo contendere.

History. Acts 1999, No. 666, § 4; 2009, No. 689, § 18.

20-13-1112. Forms — Regulations.

The Arkansas Crime Information Center, the Identification Bureau of the Department of Arkansas State Police, and the Division of Emergency Medical Services of the Department of Health shall cooperate to prepare forms and promulgate consistent regulations as necessary to implement this subchapter.

History. Acts 1999, No. 666, § 7; 2011, No. 627, § 3.

20-13-1113. Confidentiality.

(a) All criminal history checks obtained under this subchapter are confidential and are restricted to the exclusive use of the Arkansas Crime Information Center, the Identification Bureau of the Department of Arkansas State Police, the Division of Emergency Medical Services of the Department of Health, and the person who is the subject of the report.

(b) The information contained in criminal history checks shall not be released or otherwise disclosed to any other person or agency except by court order and is specifically exempt from disclosure under the Freedom of Information Act of 1967, § 25-19-101 et seq., except that the division shall furnish determinations to qualified entities.

History. Acts 1999, No. 666, § 8.

20-13-1114. Immunity.

Individuals are immune from suit or liability for damages for acts or omissions other than malicious acts or omissions occurring in the performance of duties imposed by this subchapter.

History. Acts 1999, No. 666, § 9.

20-13-1115. Applicability of subchapter.

This subchapter shall not apply to persons who render care subject to professional licenses obtained pursuant to:

(1) Section 17-27-101 et seq., regarding licensed professional counselors;

(2) The Social Work Licensing Act, § 17-103-101 et seq., regarding social workers;

(3) The Arkansas Dental Practice Act, § 17-82-101 et seq., regarding dentists;

(4) Section 17-87-101 et seq., regarding nurses;

(5) The Arkansas Occupational Therapy Practice Act, § 17-88-101 et seq., regarding occupational therapists;

(6) Section 17-92-101 et seq., regarding pharmacists;

(7) The Arkansas Physical Therapy Act, § 17-93-101 et seq., regarding physical therapists;

(8) Section 17-95-101 et seq., regarding physicians and surgeons;

(9) Section 17-96-101 et seq., regarding podiatrists;

(10) Section 17-97-101 et seq., regarding psychologists and psychological examiners;

(11) The Licensure Act of Speech-Language Pathologists and Audiologists, § 17-100-101 et seq., regarding speech-language pathologists and audiologists; or

(12) Section 20-10-401 et seq., regarding nursing home administrators.

History. Acts 1999, No. 666, § 10.

SUBCHAPTER 12 — VACCINATION PROGRAM FOR FIRST RESPONDERS

SECTION.

20-13-1201. Definitions.

20-13-1202. Vaccination program for first responders.

Effective Dates. Acts 2003, No. 1401, § 2: Apr. 15, 2003. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that first responders to a bioterrorism attack may be subjected to vaccine-preventable diseases and the first responders are in need of vaccinations to protect them against vaccine-preventable diseases in view of a bioterrorism attack and it is essential to the welfare of the State of Arkansas and its citizens to protect its first responders against a bioterrorism

attack. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

20-13-1201. Definitions.

As used in this subchapter:

(1) "Bioterrorism" means the intentional use of any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology or any naturally occurring or

bioengineered component of any microorganism, virus, infectious substance, or biological product to cause or attempt to cause death, disease, or other biological malfunction in any living organism;

(2) “Department” means the Department of Health;

(3) “Director” means the Director of the Department of Health;

(4) “Disaster location” means any geographical location where a bioterrorism attack, terrorist attack, catastrophic or natural disaster, or other emergency occurs; and

(5) “First responders” means state and local law enforcement personnel, fire department personnel, and emergency medical personnel who will be deployed to bioterrorism attacks, terrorist attacks, catastrophic or natural disasters, and emergencies.

History. Acts 2003, No. 1401, § 1.

20-13-1202. Vaccination program for first responders.

(a) The Department of Health shall offer a vaccination program for first responders who may be exposed to infectious diseases while deployed to disaster locations.

(b) Participation in the vaccination program shall be voluntary by the first responders, except for first responders who are classified as having occupational exposure to bloodborne pathogens as defined by the Occupational Safety and Health Administration Standard contained in 29 C.F.R. § 1910.1030, as in effect on January 1, 2003, who shall be required to take the designated vaccinations or as otherwise required by law.

(c) The department shall notify first responders of the availability of the vaccination program and shall provide first responders with educational materials on ways to prevent exposure to infectious disease.

(d) The department may contract with county and local health departments, not-for-profit home healthcare agencies, hospitals, and physicians to administer a vaccination program for first responders.

(e)(1) This section shall be effective upon receipt of federal funding or federal grants, or both, for administering a vaccination program for first responders.

(2) Upon receipt of federal funding, the department shall make available the vaccines required for first responders under this section.

History. Acts 2003, No. 1401, § 1.

**SUBCHAPTER 13 — PUBLIC ACCESS TO AUTOMATED EXTERNAL
DEFIBRILLATION ACT**

SECTION.

20-13-1301. Title.

20-13-1302. Legislative intent.

SECTION.

20-13-1303. Definitions.

20-13-1304. Access by public to defibrilla-

SECTION.

tors.
20-13-1305. Automated external defibrillator use and tort immunity.

SECTION.

20-13-1306. Health spas — Definition.

20-13-1301. Title.

This subchapter may be cited as the “Public Access to Automated External Defibrillation Act”.

History. Acts 2005, No. 273, § 1.

20-13-1302. Legislative intent.

The General Assembly finds that early defibrillation can sustain the life of and temporarily stabilize a person in cardiac arrest, thus helping to preserve the Arkansas family. It is the intent of the General Assembly that the public have access to automated external defibrillators for the purpose of saving the lives of persons in cardiac arrest.

History. Acts 2005, No. 273, § 1.

20-13-1303. Definitions.

As used in this subchapter:

(1) “Automated external defibrillator” means a device that:

(A) Is used to administer an electric shock through the chest wall to the heart;

(B) Has built-in computers within the device to assess the patient’s heart rhythm, judge whether defibrillation is needed, and then administer the shock;

(C) Has audible or visual prompts, or both, to guide the user through the process;

(D) Has received approval from the United States Food and Drug Administration of its premarket modification, filed pursuant to 21 U.S.C. § 360(k);

(E) Is capable of recognizing the presence or absence of ventricular fibrillation and rapid ventricular tachycardia and is capable of determining without intervention by an operator whether defibrillation should be performed; and

(F) Upon determining that defibrillation should be performed, either automatically charges and delivers an electrical impulse to an individual’s heart or charges and delivers an electrical impulse at the command of the operator;

(2) “Cardiac arrest” means a condition, often sudden, that is due to abnormal heart rhythms called arrhythmias. It is generally the result of some underlying form of heart disease;

(3) “Cardiopulmonary resuscitation” means a combination of rescue breathing and chest compressions and external cardiac massage used to sustain a person’s life until advanced assistance arrives;

(4) “Defibrillation” means administering an electrical impulse to an individual’s heart in order to stop ventricular fibrillation or rapid ventricular tachycardia;

(5) “Emergency medical services” means the transportation and medical care provided the ill or injured before arrival at a medical facility by a certified emergency medical technician or other healthcare provider and continuation of the initial emergency care within a medical facility subject to the approval of the medical staff and governing board of that facility;

(6) “Person” means any individual, partnership, association, corporation, or any organized group of persons whether incorporated or not; and

(7) “Ventricular fibrillation” means the most common arrhythmia that causes cardiac arrest. It is a condition in which the heart’s electrical impulses suddenly become chaotic, often without warning, causing the heart’s pumping action to stop abruptly.

History. Acts 2005, No. 273, § 1.

20-13-1304. Access by public to defibrillators.

(a) In order to ensure the public health and safety, a person or entity that acquires an automated external defibrillator shall ensure that:

(1) Expected automated external defibrillator users complete appropriate knowledge and skills courses at least one (1) time every two (2) years in cardiopulmonary resuscitation and automated external defibrillator use based upon current American Heart Association scientific guidelines, standards, and recommendations for providing cardiopulmonary resuscitation and the use of automated external defibrillators as published in American Heart Association, American Red Cross, or equivalent course materials;

(2) The defibrillator is maintained and tested according to the manufacturer’s operational guidelines and instructions; and

(3) Any person who renders emergency care or treatment on a person in cardiac arrest by using an automated external defibrillator activates the emergency medical services system as soon as possible and immediately reports any clinical use of the automated external defibrillator to the medical provider responding to the emergency.

(b) Any person or entity that acquires an automated external defibrillator shall notify an agent of emergency communications, 911, or vehicle dispatch center of the existence, location, and type of automated external defibrillator.

History. Acts 2005, No. 273, § 1.

20-13-1305. Automated external defibrillator use and tort immunity.

(a) Any person or entity that in good faith and without compensation renders emergency care or treatment by the use of an automated

external defibrillator is immune from civil liability for any personal injury as a result of the care or treatment or as a result of any act or failure to act in providing or arranging further medical treatment if the person acts as an ordinary, reasonably prudent person would have acted under the same or similar circumstances.

(b) The immunity from civil liability for any personal injury under subsection (a) of this section includes:

(1) A physician or medical facility that is involved with automated external defibrillator placement;

(2) Any person or entity that provides cardiopulmonary resuscitation and automated external defibrillator training to the person or entity acquiring an automated external defibrillator; and

(3) The person or entity responsible for the location where the automated external defibrillator is located or used.

(c) The immunity from civil liability under subsection (a) of this section does not apply if the personal injury results from the gross negligence or willful or wanton misconduct of the person rendering the emergency care.

(d) The requirements of § 20-13-1304 do not apply to any individual using an automated external defibrillator in an emergency setting if that individual is acting as a “Good Samaritan” under the provisions of either § 17-95-101 or § 17-95-106.

History. Acts 2005, No. 273, § 1.

20-13-1306. Health spas — Definition.

(a) As used in this section, “health spa” means any person, firm, corporation, organization, club, or association engaged in the sale of:

(1) Memberships in a program of physical exercise that includes the use of one (1) or more sauna, whirlpool, weightlifting room, massage, steam room, or exercising machine or device; or

(2) The right or privilege to use exercise equipment or facilities such as a sauna, whirlpool, weightlifting room, massage, steam room, or exercising machine or device, including, but not limited to:

(A) For-profit businesses, firms, corporations, organizations, clubs, or associations;

(B) Bona fide nonprofit organizations, including, but not limited to, the Young Men’s Christian Association, YWCA USA, Inc., or similar organizations whose functions as health spas are only incidental to the overall functions and purposes;

(C) Any organization primarily operated for the purpose of teaching a particular form of martial arts such as judo or karate;

(D) Any college or university fitness center;

(E) Any country club; or

(F) Weight-loss or weight-control services which do not provide physical exercise facilities and which do not obligate the customer for more than twenty-five (25) months.

- (b)(1) Each health spa shall have at least one (1) automated external defibrillator on the premises.
- (2) The defibrillator shall at all times be placed in the location that best provides accessibility to staff, members, and guests.
- (3) At all times during staffed business hours, the spa shall ensure that at least one (1) employee who has completed a knowledge and skills course in operating an automated external defibrillator and in cardiopulmonary resuscitation is assigned to be on duty.
- (4) An unstaffed health spa shall have on the premises:
- (A) A telephone for 911 telephone call access;
 - (B) An advisory warning that indicates that members of the unstaffed health spa should be aware that working out alone may pose risks to the health spa member's health and safety; and
 - (C) In plain view:
 - (i) A sign indicating the location of the automated external defibrillator; and
 - (ii) A sign providing instruction in the use of the automated external defibrillator and in cardiopulmonary resuscitation.
- (c) No cause of action against a health spa or its employees may arise in connection with the use or nonuse of an automated external defibrillator unless the health spa has:
- (1) Failed to purchase an automated external defibrillator as required under this section; or
 - (2) Acted with gross negligence in the use of an automated external defibrillator.
- (d) If a health spa does not comply with this section, any contract for health spa services shall be voidable at the option of the buyer.

History. Acts 2005, No. 1199, § 1; 2007, No. 827, § 158; 2007, No. 1606, § 1.

A.C.R.C. Notes. Pursuant to Acts 2007, No. 827, § 240, the amendment of § 20-

13-1306 by Acts 2007, No. 1606, § 1 supersedes the amendment of § 20-13-1306 by Acts 2007, No. 827, § 158.

SUBCHAPTER 14 — EMERGENCY CONTRACEPTION FOR VICTIMS OF SEXUAL ASSAULT

SECTION.	SECTION.
20-13-1401. Findings — Purpose.	20-13-1403. Emergency contraception information required.
20-13-1402. Definitions.	

20-13-1401. Findings — Purpose.

- (a) The General Assembly finds that:
- (1) One (1) of every six (6) women in the United States will be the victim of a sexual assault;
 - (2) Forty-four percent (44%) of the victims of a sexual assault are under eighteen (18) years of age, and eighty percent (80%) of the victims of a sexual assault are under thirty (30) years of age;
 - (3) It is estimated that sixty percent (60%) of all sexual assaults are not reported;

(4) A woman who is the survivor of a sexual assault may face the additional trauma of an unwanted pregnancy or the fear that pregnancy may result;

(5) Each year, between twenty-five thousand (25,000) and thirty-two thousand (32,000) women in the United States become pregnant as a result of sexual assaults, and approximately twenty-two thousand (22,000) of these pregnancies could be prevented if these women used emergency contraception;

(6) Standards of emergency care established by the American College of Emergency Medicine and the American Medical Association require that sexual assault survivors be counseled about their risk of pregnancy and offered emergency contraception;

(7) The National Protocol for Sexual Assault Medical Forensic Examinations issued by the United States Department of Justice Office on Violence Against Women recognizes pregnancy as an often overwhelming and genuine fear among sexual assault survivors and recommends that healthcare providers discuss treatment options with patients, including reproductive health services;

(8) The United States Food and Drug Administration has declared emergency contraception to be safe and effective in preventing unintended pregnancy and has approved over-the-counter access to the medication for women over eighteen (18) years of age;

(9) Emergency contraception is designed to prevent pregnancy if taken within one hundred twenty (120) hours after unprotected sexual intercourse, but it is most effective if taken within twenty-four (24) hours after unprotected sexual intercourse;

(10) There are inconsistent policies and practices among Arkansas hospitals for dispensing emergency contraception and providing education to sexual assault survivors; and

(11) Because emergency contraception is time-sensitive and a sexual assault survivor may have delayed seeking hospital treatment, it is critical that she be informed of this option at the time of her treatment.

(b) The purpose of this subchapter is to:

(1) Promote awareness of the availability of emergency contraception for sexual assault survivors as a compassionate response to their traumas; and

(2) Reduce the number of unintended pregnancies and induced abortions that result from sexual assault.

History. Acts 2007, No. 1576, § 1.

20-13-1402. Definitions.

As used in this subchapter:

(1)(A) "Emergency contraception" means a drug approved by the United States Food and Drug Administration that prevents pregnancy after sexual intercourse, including without limitation oral contraceptive pills.

- (B) “Emergency contraception” does not include RU-486, mifepristone, or any other drug or device that induces a medical abortion; and
- (2) “Sexual assault survivor” means a female who:

(A) Alleges or is alleged to have been the victim of sexual assault or to have been raped; and

(B) Presents as a patient for treatment with regard to the sexual assault or rape.

History. Acts 2007, No. 1576, § 1.

20-13-1403. Emergency contraception information required.

(a) All healthcare facilities that are licensed in this state and provide emergency care to sexual assault survivors shall amend their evidence-collection protocols for the treatment of sexual assault survivors to include informing the survivor in a timely manner of the availability of emergency contraception as a means of pregnancy prophylaxis and educating the sexual assault survivor on the proper use of emergency contraception and the appropriate follow-up care.

(b) This section does not require:

(1) A healthcare professional who is employed by a healthcare facility that provides emergency care to a sexual assault survivor to inform the sexual assault survivor of the availability of emergency contraception if the healthcare professional refuses to provide the information on the basis of religious or moral beliefs; or

(2) A healthcare facility to provide emergency contraception to a sexual assault survivor who is not at risk of becoming pregnant as a result of the sexual assault or who was already pregnant at the time of the sexual assault.

(c) The General Assembly encourages each healthcare facility to provide training to emergency room staff concerning the efficacy of emergency contraception and the time-sensitive nature of the drug.

(d)(1) Because emergency contraception is time-sensitive and a sexual assault survivor may seek information on or direct access to emergency contraception to prevent an unintended pregnancy resulting from the assault instead of or before seeking hospital treatment, it is critical that a sexual assault survivor has accurate information about the availability and use of emergency contraception.

(2) Therefore, the General Assembly encourages:

(A) An entity offering victim assistance or counseling and rape crisis hotlines to include information concerning the availability and use of emergency contraception; and

(B) A licensed or registered pharmacy in the State of Arkansas to distribute information concerning the availability and use of emergency contraception.

History. Acts 2007, No. 1576, § 1.

SUBCHAPTER 15 — PROTECTION FROM LIFE-THREATENING DISEASE

SECTION.

20-13-1501. Definitions.

20-13-1502. Possible exposure of emer-

gency response workers to
airborne or blood-borne
diseases — Testing.**20-13-1501. Definitions.**

As used in this subchapter:

(1) “Airborne or blood-borne disease” means a potentially life-threatening disease, including without limitation:

- (A) Tuberculosis;
- (B) Hepatitis C; and
- (C) Hepatitis B;

(2) “Emergency response worker” means:

- (A) Paramedics;
- (B) Emergency response employees;
- (C) Firefighters;
- (D) First response workers;
- (E) Emergency medical technicians;
- (F) Emergency medical services personnel;
- (G) Volunteers making an authorized emergency response; and
- (H) A person rendering services as a “Good Samaritan” under the “Good Samaritan” law, § 17-95-101;

(3) “Healthcare facility” means a hospital, nursing home, blood bank, blood center, sperm bank, or other healthcare institution; and

(4) “Healthcare provider” means any physician, nurse, paramedic, or other person providing medical, nursing, or other healthcare services of any kind.

History. Acts 2009, No. 1185, § 1.**20-13-1502. Possible exposure of emergency response workers to airborne or blood-borne diseases — Testing.**

(a)(1) Consent is not required for a healthcare provider or healthcare facility to test an individual for an airborne or blood-borne disease when a healthcare provider or an employee of a healthcare facility has a type of contact with an individual that may transmit an airborne or blood-borne disease, as determined by a physician in his or her medical judgment.

(2) The results of the tests authorized under subdivision (a)(1) of this section shall be provided by the physician ordering the tests to the affected healthcare provider’s physician or the employee’s physician and to the physician of the individual who was tested.

(b)(1) Notwithstanding any other law to the contrary, a person who performs a test under subsection (a) of this section shall not be subject to civil or criminal liability for doing so.

(2) Notwithstanding any other law to the contrary, a person who discloses a test result in accordance with the provisions of subsection (a) of this section shall not be subject to civil or criminal liability.

History. Acts 2009, No. 1185, § 1; 2011, No. 1121, § 2.

SUBCHAPTER 16 — COMMUNITY PARAMEDICS

SECTION.

20-13-1601. Definition.

20-13-1602. Community paramedics —
Licensure — Services.

SECTION.

20-13-1603. Rules.

20-13-1601. Definition.

As used in this subchapter, “community paramedic” means an individual who:

- (1) Is licensed as a paramedic;
- (2) Meets the requirements for additional licensure as a community paramedic under this subchapter; and
- (3) Provides services to:
 - (A) Discharged inpatients who have been screened for home health or hospice and either:
 - (i) Do not qualify for home health or hospice services; or
 - (ii) Are documented as having declined home health or hospice services;
 - (B) Discharged emergency department patients; and
 - (C) Pre-hospital patients.

History. Acts 2015, No. 685, § 2.

20-13-1602. Community paramedics — Licensure — Services.

(a) To be eligible for licensure by the Department of Health under the Division of Emergency Medical Services as a community paramedic, an individual shall:

- (1) Be currently licensed as a paramedic;
 - (2) Have two (2) years of full-time service as a paramedic;
 - (3) Be actively employed by a licensed paramedic ambulance service; and
 - (4) Have successfully completed a community paramedic training program from an accredited college or university approved by the Department of Health under the Division of Emergency Services.
- (b) The training program for the community paramedic shall consist of a minimum of three hundred (300) hours of classroom and clinical education as follows:

- (1) Clinical experience that is provided under the supervision of a community paramedic service medical director, advanced practice registered nurse, physician assistant, or home health nurse; and
- (2) Areas of clinical experience, including at a minimum:

- (A) Emergency department services;
- (B) Home health services;
- (C) Hospital case management; and
- (D) Public health agencies services.

(c) A community paramedic may provide services as directed by a patient care plan after the plan has been developed or approved, or both, by the patient’s physician in conjunction with the community paramedic service’s medical director.

(d) An individual is an eligible patient for community paramedic services if the individual has been identified by the individual’s treating physician as an individual for whom community paramedic services would likely:

(1) Prevent admission to or allow discharge from a nursing facility; or

(2) Prevent readmission to a hospital or nursing home.

(e) Community paramedic services are limited to:

(1) Coordination of community services;

(2) Chronic disease monitoring and education;

(3) Health assessment;

(4) Hospital discharge follow-up care;

(5) Laboratory specimen collection; and

(6) Medication compliance.

(f) For purposes of relicensure, a community paramedic shall:

(1) Complete an additional fifteen (15) hours of training beyond the relicensure requirements as a paramedic; and

(2) Be active in performing the skills of a community paramedic.

History. Acts 2015, No. 685, § 2.

20-13-1603. Rules.

(a) The Emergency Medical Services Advisory Council and the State Board of Health shall adopt rules to implement this subchapter.

(b) The rules shall consider quality assurance and adequate data collection to evaluate the utilization and effectiveness of the community paramedic licensure program.

History. Acts 2015, No. 685, § 2; 2017, No. 264, § 2.

Amendments. The 2017 amendment inserted “licensure” in (b).

SUBCHAPTER 17 — JOSHUA ASHLEY-PAULEY ACT

SECTION.

20-13-1701. Title.

20-13-1702. Legislative findings.

20-13-1703. Definitions.

SECTION.

20-13-1704. Immunity for seeking medical assistance.

20-13-1705. Construction.

20-13-1701. Title.

This subchapter shall be known and may be cited as the “Joshua Ashley-Pauley Act”.

History. Acts 2015, No. 1114, § 1.

20-13-1702. Legislative findings.

The General Assembly finds that:

(1) In the United States, drug overdose death rates more than tripled since 1990;

(2) Every day in the United States, one hundred twenty (120) people die as a result of a drug overdose while another six thousand seven hundred forty-eight (6,748) are treated in emergency departments for the misuse or abuse of drugs;

(3) Joshua Ashley-Pauley of Faulkner County died of a drug overdose in May 2014;

(4) Drug overdoses were the leading cause of death in 2012, with drug overdoses causing more deaths among people between twenty-five (25) years of age and sixty-four (64) years of age than motor vehicle traffic crashes;

(5) Overdose reporting legislation, medical amnesty legislation, or 911 Good Samaritan laws have been enacted in fourteen (14) states, including Louisiana, Oklahoma, and Tennessee, and are under consideration in several other states;

(6) In North Carolina, it is believed that at least twenty (20) lives have been saved since passage of similar legislation; and

(7) The State of Arkansas must take steps to combat the increase of drug overdoses in the state and protect the health and safety of its citizens.

History. Acts 2015, No. 1114, § 1.

20-13-1703. Definitions.

As used in this subchapter:

(1) “Drug overdose” means an acute condition resulting from, or that a reasonable person would believe to be resulting from, the consumption or use of alcohol, a controlled substance, or dangerous drug or a combination of alcohol, controlled substance, or dangerous drug by an individual, causing signs, including without limitation:

- (A) Extreme physical illness;
- (B) Decreased level of consciousness;
- (C) Respiratory depression;
- (D) Coma;
- (E) Mania; or
- (F) Death;

(2) “Emergency medical services” means:

(A) The transportation and medical care provided the ill or injured by licensed emergency medical services personnel or other healthcare providers before arrival at a medical facility; and

(B) Continuation of the initial emergency care within a medical facility subject to the approval of the medical staff and governing board of that facility;

(3) “Medical assistance” means aid provided to a person experiencing or believed to be experiencing a drug overdose by a healthcare provider acting within its scope of practice that may provide diagnosis, treatment, or emergency medical services relative to the drug overdose; and

(4) “Seeks medical assistance” means accesses or assists in accessing the 911 system or otherwise contacts or assists in contacting law enforcement or a poison control center and provides care to a person experiencing or believed to be experiencing a drug overdose.

History. Acts 2015, No. 1114, § 1.

20-13-1704. Immunity for seeking medical assistance.

(a) A person shall not be arrested, charged, or prosecuted for possession of a controlled substance in violation of § 5-64-419 if the evidence for the arrest, charge, or prosecution of the possession of a controlled substance in violation of § 5-64-419 resulted solely from seeking medical assistance if:

(1) The person in good faith seeks medical assistance for another person who is experiencing a drug overdose; or

(2) The person is experiencing a drug overdose and in good faith seeks medical assistance for himself or herself.

(b) A person shall not be subject to penalties for a violation of a permanent or temporary protective order or restraining order or sanctions for a violation of a condition of pretrial release, condition of probation, or condition of parole based on the possession of a controlled substance in violation of § 5-64-419 if the penalties or sanctions are related to the seeking of medical assistance.

History. Acts 2015, No. 1114, § 1.

20-13-1705. Construction.

This subchapter does not limit:

(1) The admissibility of any evidence:

(A) In connection with the investigation or prosecution of a crime with regard to a person who does not meet the requirements of § 20-13-1704; or

(B) With regard to other crimes committed by a person who meets the requirements of § 20-13-1704;

(2) Any seizure of evidence or contraband otherwise permitted by law; or

(3) The authority of a law enforcement officer to detain or take into custody a person in the course of an investigation or to effectuate an arrest for any offense except as provided in § 20-13-1704.

History. Acts 2015, No. 1114, § 1.

SUBCHAPTER 18 — NALOXONE ACCESS ACT

SECTION.	SECTION.
20-13-1801. Title.	20-13-1804. Opioid antagonist — Immunity.
20-13-1802. Legislative findings.	
20-13-1803. Definitions.	

20-13-1801. Title.

This subchapter shall be known and may be cited as the “Naloxone Access Act”.

History. Acts 2015, No. 1222, § 2.

20-13-1802. Legislative findings.

The General Assembly finds that:

- (1) Naloxone is a relatively inexpensive opioid antagonist developed to counter the effects of opiate overdose, specifically the life-threatening depression of the central nervous and respiratory systems;
- (2) Naloxone will not adversely affect the human body if the person who receives Naloxone is suffering from an overdose of a drug that is not an opioid;
- (3) Naloxone is clinically administered via intramuscular, intravenous, or subcutaneous injection;
- (4) Naloxone is administered outside of a clinical setting or facility intranasally via a nasal atomizer, similar to the use of a common, over-the-counter anticongestion nasal spray;
- (5) The American Medical Association has supported the lay administration of this lifesaving drug since 2012;
- (6) Similar Naloxone access laws have reversed more than ten thousand (10,000) opioid overdoses by lay people in other states;
- (7) The American Medical Association has acknowledged that more must be done to prevent these unnecessary opioid overdose fatalities that devastate families and communities;
- (8) The National Institutes of Health have found that Naloxone lacks any addictive qualities that could lead to potential abuse and that medical side effects or unintended consequences associated with the drug have not been reported; and
- (9) Any administration of Naloxone to an individual experiencing an opioid overdose must be followed by professional medical attention and treatment.

History. Acts 2015, No. 1222, § 2.

20-13-1803. Definitions.

As used in this subchapter:

(1) “Emergency medical services technician” means an individual licensed by the Department of Health at any level established by the rules adopted by the State Board of Health under § 20-13-301 et seq. and authorized to perform emergency medical services, including without limitation an EMT, Advanced EMT, paramedic, EMS Instructor, or EMS Instructor Trainer;

(2) “First responders” means state and local law enforcement personnel, fire department personnel, and emergency medical personnel who will be deployed to bioterrorism attacks, terrorist attacks, catastrophic or natural disasters, and emergencies;

(3) “Harm reduction organization” means an organization that provides direct assistance and services such as syringe exchanges, counseling, homeless services, advocacy, and drug treatment and screening to individuals at risk of experiencing a drug overdose;

(4) “Healthcare professional” means a person or entity that is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of the practice of his or her profession or as a function of an entity’s administration of the practice of medicine;

(5) “Opioid” means a drug or medication that relieves pain, including without limitation:

- (A) Hydrocodone;
- (B) Oxycodone;
- (C) Morphine;
- (D) Codeine;
- (E) Heroin; and
- (F) Fentanyl;

(6) “Opioid antagonist” means any drug that binds to opioid receptors and blocks or inhibits the effects of opioids acting on the receptors and that is approved by the United States Food and Drug Administration for the treatment of an opioid-related drug overdose; and

(7) “Opioid-related drug overdose” means an acute condition resulting from, or that a reasonable person would believe to be resulting from, the consumption or use of an opioid or another substance with which an opioid was combined by an individual with signs and symptoms that include without limitation:

- (A) Extreme physical illness;
- (B) Decreased level of consciousness;
- (C) Respiratory depression;
- (D) Coma;
- (E) Mania; or
- (F) Death.

History. Acts 2015, No. 1222, § 2.

20-13-1804. Opioid antagonist — Immunity.

(a) A healthcare professional acting in good faith may directly or by standing order prescribe and dispense an opioid antagonist to:

- (1) A person at risk of experiencing an opioid-related drug overdose;
- (2) A pain management clinic;
- (3) A harm reduction organization;
- (4) An emergency medical services technician;
- (5) A first responder;
- (6) A law enforcement officer or agency;
- (7) An employee of the State Crime Laboratory; or
- (8) A family member or friend of a person at risk of experiencing an opioid-related drug overdose.

(b) A person acting in good faith who reasonably believes that another person is experiencing an opioid-related drug overdose may administer an opioid antagonist that was prescribed and dispensed under section (a) of this section.

(c) The following individuals are immune from civil liability, criminal liability, or professional sanctions for administering, prescribing, or dispensing an opioid antagonist under this section:

- (1) A healthcare professional who prescribes an opioid antagonist under subsection (a) of this section;
- (2) A healthcare professional or pharmacist who acts in good faith and in compliance with the standard of care that dispenses an opioid antagonist under subsection (a) of this section; and
- (3) A person other than a healthcare professional who administers an opioid antagonist under subsection (b) of this section.

History. Acts 2015, No. 1222, § 2; inserted present (a)(7); and redesignated 2017, No. 70, § 1. former (a)(7) as (a)(8).

Amendments. The 2017 amendment

CHAPTER 14

INDIVIDUALS WITH DISABILITIES

SUBCHAPTER.

1. GENERAL PROVISIONS. [RESERVED.]
2. GOVERNOR’S COMMISSION ON PEOPLE WITH DISABILITIES.
3. RIGHTS GENERALLY.
4. AMPUTEE DISABLED. [REPEALED.]
5. EARLY INTERVENTION PROGRAM FOR INFANTS AND TODDLERS.
6. ARCHITECTURAL BARRIERS ACCESSIBILITY. [REPEALED.]
7. HEAD INJURIES.
8. INTERPRETERS BETWEEN HEARING INDIVIDUALS AND INDIVIDUALS WHO ARE DEAF, DEAFBLIND, HARD OF HEARING, OR ORAL DEAF.

RESEARCH REFERENCES

ALR. Educational placement of handicapped children. 23 A.L.R.4th 740.

State legislation forbidding discrimination in housing on account of physical handicap. 28 A.L.R.4th 685.

Discrimination "because of handicap" or "on basis of handicap" under state statutes prohibiting job discrimination on ac-

count of handicap. 81 A.L.R.4th 144.

Validity and construction of state statutes requiring construction of handicapped access facilities in buildings open to public. 82 A.L.R.4th 121.

Visual impairment as handicap or disability under state employment discrimination law. 77 A.L.R.5th 595.

SUBCHAPTER 1 — GENERAL PROVISIONS

[Reserved.]

SUBCHAPTER 2 — GOVERNOR'S COMMISSION ON PEOPLE WITH DISABILITIES

SECTION.

- 20-14-201. Legislative policy.
- 20-14-202. Creation — Members.
- 20-14-203. Ex officio members.
- 20-14-204. Officers.
- 20-14-205. Meetings.

SECTION.

- 20-14-206. Powers and duties.
- 20-14-207. Executive board.
- 20-14-208. Subcommittees.
- 20-14-209. Administrative support.
- 20-14-210. Gifts, grants, and donations.

Effective Dates. Acts 1985, No. 911, § 13: Apr. 15, 1985. Emergency clause provided: "In recognition of the pressing problems of people with disabilities, it is hereby found and determined by the General Assembly that a special Commission is needed to address these problems and it is imperative that this Commission com-

mence operation immediately and that this Act is immediately necessary to so provide. Therefore, an emergency is hereby declared to exist and this Act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

20-14-201. Legislative policy.

This law is enacted to provide for a Governor's commission to carry on a continuing program to promote the interests of persons with disabilities in this state, in recognition that:

(1) Arkansas has a public awareness of, and community interest in, the problems of persons with disabilities and that the awareness and interest must be heightened in order to enhance understanding of their problems;

(2) There exists a need to assure that the special requirements of persons with disabilities are appropriately considered in state programs;

(3) Existing programs for persons with disabilities require coordination to eliminate fragmentation of responsibility; and

(4) There exists a critical need to provide individuals seeking information or assistance regarding services and programs for persons with disabilities with a simple means of obtaining appropriate information and referrals.

History. Acts 1985, No. 911, § 1; A.S.A. 1947, § 82-2908.

20-14-202. Creation — Members.

(a) There is created a commission to be known as the “Governor’s Commission on People with Disabilities” composed of eleven (11) members appointed by the Governor, subject to confirmation by the Senate.

(b)(1) Six (6) of the members shall be persons with disabilities.

(2) Membership terms shall be four (4) years.

(3) Vacancies shall be filled for the remainder of the term of the original appointment by the Governor.

(4) Members shall receive no compensation for serving on the commission.

(5) The vacancies shall be filled in the manner prescribed by law.

(c) The commission shall be nonpartisan, nonprofit, and shall not engage in the dissemination of partisan principles.

History. Acts 1985, No. 911, §§ 2, 6, 8, 11; A.S.A. 1947, §§ 82-2909, 82-2913, 82-2915, 82-2917; Acts 2017, No. 540, § 44.

Publisher’s Notes. Acts 1985, No. 911, § 2 provided, in part, that terms of office would be staggered so that not more than one-third of the membership would be appointed each year.

Amendments. The 2017 amendment substituted “eleven (11)” for “a maximum of twenty-five” in (a); substituted “Six (6)” for “Thirteen (13)” in (b)(1); rewrote (b)(2); deleted former (b)(5); and redesignated former (b)(6) as present (b)(5).

20-14-203. Ex officio members.

(a) The Director of the Department of Human Services, the deputy director of the appropriate division as determined by the Director of the Department of Human Services, and the Director of the Department of Workforce Services or any director, commissioner, or administrator of successors’ agencies shall serve as ex officio members of the Governor’s Commission on People with Disabilities.

(b) The Governor shall also appoint two (2) members of the General Assembly to serve as ex officio members of the commission.

History. Acts 1985, No. 911, § 3; A.S.A. 1947, § 82-2910.

20-14-204. Officers.

(a) The Chair of the Governor’s Commission on People with Disabilities shall be appointed biennially by the Governor and serve at the pleasure of the Governor.

(b) The chair shall select an executive board.

(c) The Executive Board of the Governor's Commission on People with Disabilities is empowered to select from the commission membership a vice chair should such a position be desirable.

(d) The chair, or in his or her absence the Vice Chair of the Governor's Commission on People with Disabilities, shall exercise general supervision of all commission affairs.

(e) The chair shall preside over all meetings of the commission and executive board, appoint subcommittees and chairs, and serve as an ex officio member of all subcommittees.

History. Acts 1985, No. 911, § 7; A.S.A. 1947, § 82-2914.

20-14-205. Meetings.

(a) A notice of regular and special meetings shall be mailed to members of the Governor's Commission on People with Disabilities not less than ten (10) days in advance. An agenda for the meeting shall accompany the notice of meeting.

(b) A quorum shall consist of not less than one-third ($\frac{1}{3}$) of the membership plus one (1) additional member.

(c) The conduct of all meetings shall be governed by Robert's Rules of Order, Revised, unless a majority of those attending vote to lay rules aside for a particular meeting.

History. Acts 1985, No. 911, § 8; A.S.A. 1947, § 82-2915.

20-14-206. Powers and duties.

The Governor's Commission on People with Disabilities shall:

(1) Advise and assist the Governor in developing policies designed to meet the needs of citizens with disabilities;

(2) Help coordinate state and private provider programs and activities relating to persons with disabilities;

(3) Cooperate with state agencies and private providers to assure that the services which the Governor and the General Assembly have authorized for persons with disabilities are, in fact, provided;

(4) Cooperate with and assist political subdivisions of the state and private providers in the development of local programs for persons with disabilities, including, but not limited to, coordination and community planning, information services, counseling services, dissemination of information, and volunteer activities;

(5) Stimulate community interest in the problems of persons with disabilities and promote public awareness of resources available for such persons;

(6) Refer persons seeking advice, assistance, and available services in connection with particular problems of persons with disabilities to the appropriate departments and agencies of the state and federal

governments or to agencies providing services by contract with the governmental entities as well as other private providers;

(7) Consult and cooperate with universities, colleges, and educational institutions in the state for the development of courses of study for persons engaged in public and private programs for persons with disabilities;

(8) Make or cause to be made such studies of needs of persons with disabilities as may be appropriate;

(9) Serve as a clearinghouse for information relating to the needs of persons with disabilities;

(10) Sponsor conferences relating to problems of and services for persons with disabilities;

(11) Assist state and local governments in eliminating obstacles to dignity and achievement which persons with disabilities may face as a result of a government and society unaware of or insensitive to their needs;

(12) Examine federal, state, and local programs for persons with disabilities and provide assistance when greater coordination between federal, state, and local programs is needed; and

(13) Cooperate with the General Assembly and the President's Committee on Employment of People with Disabilities.

History. Acts 1985, No. 911, § 5; A.S.A. 1947, § 82-2912; Acts 1997, No. 208, § 15.

A.C.R.C. Notes. Acts 1997, No. 208, § 1, as reenacted by Acts 2017, No. 255, § 1, provided: "Legislative intent and purpose. The General Assembly hereby acknowledges that many of the laws relating to individuals with disabilities are antiquated, functionally outmoded, deroga-

tory, and ambiguous or are inconsistent with more recently enacted provisions of the law. Consequently, it is the intent of the General Assembly and the purpose of this act to clarify the relevant chapters of Titles 1, 6, 9, 13, 14, 16, 17, 20, 22, 23, and 27 of the Arkansas Code of 1987 Annotated."

20-14-207. Executive board.

(a) The Chair of the Governor's Commission on People with Disabilities shall name an executive board from the membership consisting of no more than five (5) members, taking into consideration that consumer representation must be assured.

(b) The Executive Board of the Governor's Commission on People with Disabilities shall be responsible for the following activities:

(1) Appointing, subject to the personnel law, such staff as is necessary to carry out the objectives of the Governor's Commission on People with Disabilities;

(2) Acting on behalf of the commission between regular meetings of the full commission;

(3) Establishing a schedule for regular commission meetings and holding such other meetings of the executive board as may be necessary;

(4) Preparing an annual plan of work for the commission, subject to the approval of the commission;

(5) Assuring that commission activities coordinate with those of other public and private agencies responsible for providing services to disabled citizens;

(6) Scheduling a public hearing on any commission-related matter if a hearing is required by state law or deemed necessary by the commission; and

(7) Establishing such subcommittees as may be necessary to carry out the powers and duties of the commission.

History. Acts 1985, No. 911, § 8; A.S.A. 1947, § 82-2915.

20-14-208. Subcommittees.

(a) The Executive Board of the Governor's Commission on People with Disabilities shall establish such subcommittees as it determines necessary.

(b) Membership of subcommittees shall not be limited to members of the Governor's Commission on People with Disabilities.

(c) Subcommittees shall maintain written records of their activities and submit them to the Chair of the Governor's Commission on People with Disabilities.

History. Acts 1985, No. 911, § 10; A.S.A. 1947, § 82-2916.

20-14-209. Administrative support.

(a) The appropriate division as determined by the Director of the Department of Human Services or any other agency or division as the Governor shall designate shall provide administrative support to the Governor's Commission on People with Disabilities.

(b) A representative of the appropriate division as determined by the director or any other agency or division as the Governor shall designate shall be appointed as executive director to effect the coordination between the division and the Chair of the Governor's Commission on People with Disabilities in the arrangement of the support.

History. Acts 1985, No. 911, § 4; A.S.A. 1947, § 82-2911; Acts 2017, No. 264, § 3. substituted "Department of Human Services" for "Department of Health and Human Services" in (a).

Amendments. The 2017 amendment

20-14-210. Gifts, grants, and donations.

(a) The Governor's Commission on People with Disabilities may receive any gifts, grants, or donations made for any of the purposes of its program.

(b) The commission may disburse and administer the gifts, grants, and donations in accordance with the conditions established by the Executive Board of the Governor's Commission on People with Disabilities.

History. Acts 1985, No. 911, § 12;
A.S.A. 1947, § 82-2918.

SUBCHAPTER 3 — RIGHTS GENERALLY

SECTION.

- 20-14-301. Policy.
- 20-14-302. Penalty.
- 20-14-303. Rights generally.
- 20-14-304. Right to be accompanied by service animal — Penalty and restitution for killing or injuring a service animal or search and rescue dog — Definition.
- 20-14-305. Access to housing accommodations.

SECTION.

- 20-14-306. Reasonable precautions by drivers.
- 20-14-307. Signs for individuals with disabilities.
- 20-14-308. Guide dog and service dog access.
- 20-14-309. Website accessibility — Compliance.

RESEARCH REFERENCES

Ark. L. Rev. Flaccus, Handicap Discrimination Legislation, etc., 40 Ark. L. Rev. 261.

20-14-301. Policy.

(a) It is the policy of this state to accord individuals with visual, hearing, or other physical disabilities all rights and privileges of other persons with respect to the use of public streets, highways, sidewalks, public buildings, public facilities, public carriers, public housing accommodations, public amusement and resort areas, and other public areas to which the public is invited, subject only to the limitations and conditions established by law and applicable to all persons and subject to the special limitations and conditions prescribed in this subchapter for individuals with visual, hearing, or other physical disabilities.

(b) It is further the policy of this state that individuals with visual, hearing, or other physical disabilities shall be employed in state service, in the service of political subdivisions of this state, in the public schools, and in all other employment supported in whole or in part by public funds, on the same terms and conditions as individuals with visual, hearing, or other physical disabilities, unless it is shown that the visual, hearing, or other physical disability of a person prevents the performance of the work involved.

History. Acts 1973, No. 484, § 1; 1979, No. 574, § 1; A.S.A. 1947, § 82-2901.

20-14-302. Penalty.

Any person, firm, or corporation, or the agent of any person, firm, or corporation, who denies or interferes with the admittance to or enjoyment of public facilities and housing accommodations by an individual with visual, hearing, or other physical disabilities or otherwise interferes with the rights of an individual with visual, hearing, or other physical disabilities shall be guilty of a misdemeanor.

History. Acts 1973, No. 484, § 6; 1979, No. 574, § 1; A.S.A. 1947, § 82-2906.

20-14-303. Rights generally.

(a) Individuals with visual, hearing, or other physical disabilities shall have the same rights and privileges as other persons to the full use and enjoyment of:

(1) The public streets, highways, sidewalks, walkways, public buildings, public facilities, and other public places;

(2) All common carriers and other public conveyances or modes of transportation, whether by air, land, or water;

(3) All hotels, motels, lodging places, and housing accommodations;

(4) Other places of public accommodation, amusement, or resort; and

(5) All other places to which the general public is invited.

(b) The rights and privileges are subject only to the limitations and conditions established by law and applicable to all persons and subject to the special limitations and conditions prescribed in this subchapter with respect to individuals with visual, hearing, or other physical disabilities.

History. Acts 1973, No. 484, § 2; 1979, No. 574, § 1; A.S.A. 1947, § 82-2902.

20-14-304. Right to be accompanied by service animal — Penalty and restitution for killing or injuring a service animal or search and rescue dog — Definition.

(a) Every individual with visual, hearing, or other disabilities has the right to be accompanied by a service animal especially trained to do work or to perform tasks for the benefit of an individual with a disability in or upon any and all public ways, public places, and other public accommodations and housing accommodations prescribed in § 20-14-303 and to be accompanied by a service dog as defined in Title II and Title III of the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq., as it existed on January 1, 2017, and shall not be required to pay any extra fee or charge for the service animal.

(b) However, any individual with visual, hearing, or other physical disabilities accompanied by a service animal in any public way, public place, public accommodation, or housing accommodation shall be liable for any damage caused to the premises or facilities by the animal.

(c) As used in this section, “search and rescue dog” means any dog:

- (1) In training for or trained for the purpose of search and rescue;
- (2) Owned by an independent handler or a member of a search and rescue team; and
- (3) Used in conjunction with local law enforcement or emergency services organizations for the purpose of locating missing persons or evidence of arson.
- (d) Any person who without just cause purposely kills or injures any service animal described in this section or any search and rescue dog is guilty of a Class D felony.
- (e) Any person who kills or injures any service animal described in this section or any search and rescue dog shall make restitution to the owner of the animal.

History. Acts 1973, No. 484, § 3; 1979, No. 574, § 1; A.S.A. 1947, § 82-2903; Acts 1995, No. 266, § 1; 1999, No. 571, § 2; 2017, No. 652, §§ 1, 2.

A.C.R.C. Notes Acts 2017, No. 652, § 1 provided: “Title. This act shall be known and may be cited as the ‘Patricia Heath Act’.”

Amendments. The 2017 amendment in (a), substituted “disabilities has” for “physical disabilities shall have” and inserted “and to be accompanied by a service dog as defined in Titles II and III of the Americans with Disabilities Act of 1990, 42 U.S.C. 12101 et seq., as it existed on January 1, 2017”.

RESEARCH REFERENCES

ALR. What Constitutes “Service Animal” and Accommodation Thereof, Under Americans with Disabilities Act (ADA). 75 A.L.R. Fed. 2d 49.

20-14-305. Access to housing accommodations.

- (a) Individuals with visual, hearing, or other physical disabilities shall be entitled to full and equal access, as other members of the general public, to all housing accommodations offered for rental, lease, or compensation in this state subject only to the conditions and limitations established by law and applicable alike to other persons.
- (b) The provisions of this section with respect to the rights of individuals with visual, hearing, or other physical disabilities to equal access to housing accommodations shall not be deemed to include any accommodations in a facility which is designed and used primarily as a single family residence and a portion of which is rented, leased, or furnished for compensation.
- (c) Nothing in this section shall be deemed to require any person renting, leasing, or otherwise providing housing accommodations for compensation to modify his or her accommodations in any way or to provide a higher degree of care for an individual with visual, hearing, or other physical disabilities than for an individual without visual, hearing, or other physical disabilities.

History. Acts 1973, No. 484, § 5; 1979, No. 574, § 1; A.S.A. 1947, § 82-2905.

20-14-306. Reasonable precautions by drivers.

The driver of a vehicle approaching a person with a visual or hearing disability who is carrying a cane which is predominately white or metallic in color with or without a red tip or using a guide or hearing ear dog or the driver of a vehicle approaching a person with another physical disability shall take all reasonable precautions to avoid injury to the pedestrian with visual, hearing, or other physical disabilities.

History. Acts 1973, No. 484, § 4; 1979, No. 574, § 1; A.S.A. 1947, § 82-2904.

20-14-307. Signs for individuals with disabilities.

(a) State agencies which require any persons, agencies, boards, commissions, businesses, or other entities to display signs for individuals with disabilities shall require those persons, agencies, boards, commissions, businesses, or other entities to display only the blue and white international symbol of access.

(b) This section shall have no retroactive effect, applying only to signs installed subsequent to this section's taking effect.

(c) This section shall apply only if installation of a required sign can be achieved without creating a negative financial impact on any persons, agencies, boards, commissions, businesses, or other entities required to display signs for individuals with disabilities.

History. Acts 2001, No. 992, § 1.

14-306 may not apply to this section which

A.C.R.C. Notes. References to "this subchapter" in §§ 20-14-301 through 20-

was enacted subsequently.

20-14-308. Guide dog and service dog access.

(a) An individual with visual, hearing, or other physical disabilities and his or her guide, signal, or service dog or a dog trainer in the act of training a guide, signal, or service dog shall not be denied admittance to or refused access to the following because of the dog:

(1) Any street or highway;

(2) Any sidewalk or walkway;

(3) Any common carrier, airplane, motor vehicle, railroad train, bus, streetcar, boat, or any other public conveyance or mode of transportation;

(4) Any hotel, motel, or other place of lodging;

(5) Any public building maintained by any unit or subdivision of government;

(6) Any building to which the general public is invited;

(7) Any educational facility or college dormitory;

(8) Any restaurant or other place where food is offered for sale to the public; or

(9) Any other place of public accommodation, amusement, convenience, or resort to which the general public or any classification of

persons from the general public is regularly, normally, or customarily invited within the State of Arkansas.

(b) The individual with visual, hearing, or other physical disabilities, or dog trainer in the act of training a guide, signal, or service dog shall not be required to pay any additional charges for his or her guide, signal, or service dog but shall be liable for any damage done to the premises by the dog.

History. Acts 2003, No. 1107, § 1.

A.C.R.C. Notes. References to “this subchapter” in §§ 20-14-301 through 20-

14-306 may not apply to this section, which was enacted subsequently.

RESEARCH REFERENCES

ALR. What Constitutes “Service Animal” and Accommodation Thereof, Under Americans with Disabilities Act (ADA). 75 A.L.R. Fed. 2d 49.

U. Ark. Little Rock L. Rev. Survey of Legislation, 2003 Arkansas General Assembly, Public Health and Welfare, Guide Dogs, 26 U. Ark. Little Rock L. Rev. 464.

20-14-309. Website accessibility — Compliance.

(a)(1) Before filing a civil action or petition for injunctive relief based on a claim that an entity’s website does not conform with applicable law, codes, guidelines, or standards regulating the functionality of an entity’s website to accommodate a person with a disability as defined by the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq., the aggrieved party shall notify the entity in writing of the aggrieved party’s allegation that the website does not comply with applicable law, codes, guidelines, or standards regulating the functionality of an organization’s website to accommodate persons with a disability as defined by the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq., and the specific violations that the aggrieved party asserts.

(2) The specific violations alleged in the written notice under subdivision (a)(1) of this section shall include without limitation the alleged violation, alleged harm, and date of alleged harm.

(3) The notice shall be sent by certified mail with return receipt requested at least one hundred twenty (120) days before the filing of a petition for injunctive relief.

(4) The lack of the written notice under or compliance with this subsection may be used as a basis for dismissal by a court and may be used by a court as a mitigating factor in any remedy ordered by the court.

(b)(1) An entity that corrects the website that is allegedly in violation as described in the written notice under subsection (a) of this section within one hundred twenty (120) days of receipt of the written notice under subsection (a) of this section may use that fact as an affirmative defense to a civil action or petition for injunctive relief.

(2) The affirmative defense under subdivision (b)(1) of this section shall be proven by a preponderance of the evidence and may not be rebutted.

(3) A defendant in a civil action or petition for injunctive relief that prevails in that action due to the raising and successful proving of the affirmative defense under subdivision (b)(1) of this section shall be entitled to all reasonable costs of litigation, including attorney's fees.

History. Acts 2017, No. 784, § 1.

SUBCHAPTER 4 — AMPUTEE DISABLED

SECTION.

20-14-401 — 20-14-404. [Repealed.]

20-14-401 — 20-14-404. [Repealed.]

Publisher's Notes. This subchapter, concerning disabled amputees, was repealed by Acts 1999, No. 789, § 1. The subchapter was derived from the following sources:

20-14-401. Acts 1985, No. 1020, § 1; A.S.A. 1947, § 82-2919.

20-14-402. Acts 1985, No. 1020, § 2; A.S.A. 1947, § 82-2920.

20-14-403. Acts 1985, No. 1020, § 3; A.S.A. 1947, § 82-2921.

20-14-404. Acts 1985, No. 1020, § 4; A.S.A. 1947, § 82-2922.

SUBCHAPTER 5 — EARLY INTERVENTION PROGRAM FOR INFANTS AND TODDLERS

SECTION.

20-14-501. Legislative determination.

20-14-502. Definitions.

20-14-503. Statewide system of programs — Minimum requirements.

20-14-504. Assessment — Individualized family service plan.

SECTION.

20-14-505. Disposition of funds.

20-14-506. Procedural safeguards.

20-14-507. Nonsubstitution of funds — Other benefits not reduced.

20-14-508. State Interagency Council.

Preambles. Acts 1991, No. 393 contained a preamble which read: "Whereas, Arkansas Code Annotated § 20-14-503 establishes minimum components for the statewide system for early intervention program for infants and toddlers with handicaps and their families; and

"Whereas, efficient and timely delivery of service to such individuals requires the Department of Health and the Department of Human Services to share information relating to such individuals and their families."

Cross References. Children with disabilities, special education, § 6-41-101 et seq.

Effective Dates. Acts 1997, No. 250, § 258; Feb. 24, 1997. Emergency clause provided: "It is hereby found and determined by the General Assembly that Act

1211 of 1995 established the procedure for all state boards and commissions to follow regarding reimbursement of expenses and stipends for board members; that this act amends various sections of the Arkansas Code which are in conflict with the Act 1211 of 1995; and that until this cleanup act becomes effective conflicting laws will exist. Therefore an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it

shall become effective on the date the last house overrides the veto.”

20-14-501. Legislative determination.

(a) The General Assembly finds that there is an urgent and substantial need to:

(1) Enhance the development of infants and toddlers with developmental delays and to minimize their potential for developmental delay;

(2) Reduce the educational costs to our society, including our state’s schools, by minimizing the need for special education and related services after the infants and toddlers with developmental delays reach school age;

(3) Minimize the likelihood of institutionalization of infants and toddlers with developmental delays and to maximize the potential for their independent living in society; and

(4) Enhance the capacity of families to meet the special needs of their infants and toddlers with developmental delays.

(b) It is therefore the policy of this state to:

(1) Develop and implement a statewide, comprehensive, coordinated, multidisciplinary interagency program of early intervention services for infants and toddlers with developmental delays and their families;

(2) Coordinate payment for early intervention services from federal, state, local, and private sources, including public and private insurance coverage; and

(3) Provide quality early intervention services and to expand and improve existing early intervention services being provided to infants and toddlers with developmental delays and their families.

History. Acts 1987, No. 658, § 1.

20-14-502. Definitions.

As used in this subchapter:

(1) “Council” means the State Interagency Council;

(2) “Developmental delay” means a child is delayed in any one (1) or more of the following areas:

(A) Physical development;

(B) Cognitive development;

(C) Language and speech development;

(D) Psycho-social development; or

(E) Self-help skills;

(3) “Early intervention services” means developmental services which:

(A) Are provided under public supervision through licensure or for accreditation by the appropriate state agency;

(B) Are provided at no cost except when federal or state law or regulations provide for a system of payments by families, including a schedule of sliding fees;

(C) Are designed to meet a disabled infant's or toddler's developmental needs in any one (1) or more of the following areas:

- (i) Physical development;
- (ii) Cognitive development;
- (iii) Language and speech development;
- (iv) Psycho-social development; or
- (v) Self-help skills;

(D) Meet the standards of the state, including the requirements in this section;

(E) Include:

- (i) Family training, counseling, and home visits;
- (ii) Special habilitation and education instruction;
- (iii) Speech pathology and audiology;
- (iv) Occupational therapy such as fine motor skills;
- (v) Physical therapy;
- (vi) Psychological services;
- (vii) Case management services at the service delivery level;
- (viii) Medical services for diagnostic or evaluation purposes;
- (ix) Early identification, screening, and assessment services; and
- (x) Health services necessary to enable the infant or toddler to

benefit from other early intervention services;

(F) Are provided by qualified personnel, including:

(i) Certified special educators or training technicians supervised by special educators;

- (ii) Speech and language pathologists and audiologists;
- (iii) Occupational therapists;
- (iv) Physical therapists;
- (v) Psychologists;
- (vi) Social workers;
- (vii) Nurses;
- (viii) Nutritionists; and
- (ix) Physicians; and

(G) Are provided in conformity with an individualized family service plan adopted in accordance with this subchapter; and

(4) "Infants and toddlers with developmental delays" means individuals from birth through two (2) years of age, inclusive, who need early intervention services because they:

(A) Are experiencing developmental delays as measured by appropriate diagnostic instruments and procedures in one (1) or more of the following areas:

- (i) Cognitive development;
- (ii) Physical development;
- (iii) Language and speech development;
- (iv) Psycho-social development; or
- (v) Self-help skills; or

(B) Have a diagnosed physical or mental condition which has a high probability of resulting in developmental delay or are at risk of having substantial delays if early intervention services are not provided.

History. Acts 1987, No. 658, § 2.

20-14-503. Statewide system of programs — Minimum requirements.

(a) A statewide system of coordinated, comprehensive, multidisciplinary, interagency programs providing appropriate early intervention services to all developmentally delayed infants and toddlers and their families shall include the minimum components under subsection (b) of this section.

(b) The statewide system required by subsection (a) of this section shall include, at a minimum:

(1) A definition of the term “developmentally delayed” that shall be used by the state in carrying out programs under this section;

(2) Timetables for ensuring appropriate early intervention services available to all developmentally delayed infants and toddlers in the state consistent with the federal timetables for the implementation of Pub. L. No. 99-457;

(3) A timely, comprehensive, multidisciplinary evaluation of the functioning of each developmentally delayed infant and toddler in the state and the needs of the families to appropriately assist in the development of the developmentally delayed infant or toddler;

(4) For each developmentally delayed infant and toddler in the state, an individualized family service plan in accordance with federal regulations under Pub. L. No. 99-457, including case management services in accordance with the service plan;

(5) A comprehensive child-find system, consistent with federal requirements, including a system for making referrals to service providers that includes timelines and provides for the participation by primary referral sources;

(6) A public awareness program focusing on early identification of infants and toddlers with developmental delays;

(7) A central directory which includes early intervention services, resources, and experts available in the state, and research and demonstration projects being conducted in the state;

(8) A comprehensive system of personnel development;

(9) A single line of responsibility in a lead agency designated or established by the Governor for carrying out:

(A) The general administration and supervision of programs and activities receiving assistance under Pub. L. No. 99-457, and the monitoring of programs and activities used by the state to carry out Part H of Pub. L. No. 99-457, whether or not such programs or activities receive Part H assistance, to ensure that the state complies with the requirements of Part H of Pub. L. No. 99-457;

(B) The identification and coordination of all available resources within the state from federal, state, local, and private sources;

(C) The assignment of financial responsibility to the appropriate agency;

(D) The development of procedures to ensure that services are provided to infants and toddlers with developmental delays and their

families in a timely manner pending the resolution of any disputes between public agencies or service providers;

(E) The resolution of intraagency and interagency disputes; and

(F) The entry into formal interagency agreements that define the financial responsibility of each agency for paying for early intervention services, consistent with state law, and procedures for resolving disputes that include all additional components necessary to ensure meaningful cooperation and coordination;

(10) A policy pertaining to the contracting or making of other arrangements with service providers to provide early intervention services in the state, consistent with the provisions of this section, including the contents of the application used and the conditions of the contract or other arrangements;

(11) A procedure for securing timely reimbursement of funds;

(12) Procedural safeguards with respect to programs;

(13) Policies and procedures relating to the establishment and maintenance of standards to ensure that personnel necessary to carry out this subchapter are appropriately and adequately prepared and trained, including:

(A) The establishment and maintenance of standards which are consistent with any state-approved or state-recognized certification, licensing, registration, or other comparable requirements which apply to the area in which personnel are providing early intervention services; and

(B) To the extent that the standards are not based on the highest requirements in the state applicable to a specific profession or discipline, the steps the state is taking to require the retraining or hiring of personnel who meet appropriate professional requirements in the state;

(14) A system for compiling data on the numbers of infants and toddlers with disabilities and their families in the state in need of appropriate early intervention services, which may be based on a sampling of data, the number of such infants and toddlers and their families served, the types of services provided, which may be based on a sampling of data, and other information required by the United States Secretary of Education;

(15) A process for increasing early intervention services and developing services in unserved areas by giving existing providers an opportunity to provide additional services in their service areas and by implementing a request for a proposal process for developing services in areas where there is no existing provider; and

(16)(A) An interagency agreement entered into by the Department of Health and the Department of Human Services providing that the names and addresses from birth records of the infants or toddlers and their families who, based on the information ascertainable from those birth records, are eligible for early intervention services shall be made available between these agencies.

(B) The agency requesting or receiving confidential information pursuant to the interagency agreement shall take appropriate mea-

asures to protect and maintain the confidentiality of the information and shall not release or disclose the information except as necessary to accomplish the objectives of the system.

History. Acts 1987, No. 658, § 3; 1991, No. 393, § 1; 1991, No. 1017, § 2; 1993, No. 937, § 1.

U.S. Code. Pub. L. No. 99-457, referred to in this section and known as the Education of the Handicapped Act Amend-

ments of 1986, is no longer codified in the U.S. Code. For current provisions, which repealed and replaced the former provisions, see the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 et seq.

20-14-504. Assessment — Individualized family service plan.

(a) Each infant or toddler with disabilities and the infant's or toddler's family shall receive:

(1) Multidisciplinary assessment of unique needs and the identification of services appropriate to meet these needs; and

(2) A written individualized family service plan developed by a multidisciplinary team, including the parent or guardian, as required by subsection (d) of this section.

(b) The individualized family service plan shall be evaluated one (1) time a year, and the family shall be provided a review of the plan at six-month intervals, or more often when appropriate, based on infant or toddler and family needs.

(c) The individualized family service plan shall be developed within a reasonable time after the assessment required by subdivision (a)(1) of this section is completed. With the parent's or guardian's consent, early intervention services may commence before the completion of the assessment.

(d) The individualized family service plan shall be in writing and contain:

(1) A statement of the infant's or toddler's present level of physical development, cognitive development, language and speech development, psycho-social development, and self-help skills, based on acceptable objective criteria;

(2) A statement of the family's strengths and needs relating to enhancing the development of the family's infant or toddler with disabilities;

(3) A statement of the major outcomes expected to be achieved for the infant and toddler and the family, the criteria, procedures, and timeliness used to determine the degree to which progress toward achieving the outcomes is being made, and whether modifications or revisions of the outcomes are necessary;

(4) A statement of specific early intervention services necessary to meet the unique needs of the infant or toddler and the family, including the frequency, intensity, and method of delivering services;

(5) The projected dates for initiation of services and the anticipated duration of the services;

(6) The name of the case manager from the profession most immediately relevant to the infant's, toddler's, or family's needs who will be

responsible for the implementation of the plan and coordination with the other agencies and persons; and

(7) The steps to be taken supporting the transition of the disabled toddler to services provided to three-year-olds to five-year-olds to the extent that such services are considered appropriate.

History. Acts 1987, No. 658, § 4.

20-14-505. Disposition of funds.

(a) In addition to using funds provided under this subchapter to plan, develop, and implement the statewide system required by Pub. L. No. 99-457, the state shall use these funds:

(1) For direct services for infants and toddlers with disabilities that are not otherwise provided from other public or private sources; and

(2) To expand and improve on services for infants and toddlers with disabilities that are otherwise available.

(b) A maximum of ten percent (10%) of these funds may be used during the first year for central agency and State Interagency Council expenses.

History. Acts 1987, No. 658, § 5; 1997, No. 208, § 16.

A.C.R.C. Notes. Acts 1997, No. 208, § 1, as reenacted by Acts 2017, No. 255, § 1, provided: "Legislative intent and purpose. The General Assembly hereby acknowledges that many of the laws relating to individuals with disabilities are antiquated, functionally outmoded, derogatory, and ambiguous or are inconsistent

with more recently enacted provisions of the law. Consequently, it is the intent of the General Assembly and the purpose of this act to clarify the relevant chapters of Titles 1, 6, 9, 13, 14, 16, 17, 20, 22, 23, and 27 of the Arkansas Code of 1987 Annotated."

U.S. Code. As to Pub. L. No. 99-457, see note, § 20-14-503.

20-14-506. Procedural safeguards.

The procedural safeguards shall be the same as required under Pub. L. No. 94-142 and Pub. L. No. 99-457 and shall provide the following at a minimum:

(1)(A) The timely administrative resolution of complaints by parents. Any party aggrieved by the findings and decision regarding a complaint shall have the right to bring a civil action with respect to the complaint which may be brought in any state court of competent jurisdiction or in a district court of the United States without regard to the amount in controversy.

(B) In any action brought under this subdivision (1), the court shall receive the records of the administrative proceedings, shall hear additional evidence at the request of a party, and shall grant relief as the court determines is appropriate, basing its decision on the preponderance of the evidence;

(2) The right to confidentiality of personally identifiable information which shall be protected through procedures such as appropriate access lists, sign-offs, and procedures for handling records;

(3) The opportunity for parents or guardians to examine records relating to assessment, screening, eligibility determinations, and the development and implementation of the individualized family service plan;

(4) Procedures to protect the rights of the infants and toddlers with disabilities whenever the parents or guardian of the child is not known or is unavailable or whenever the child is a ward of the state. The procedures shall include the assignment of an individual who shall not be an employee of the state agency providing services to act as a surrogate for the parents or guardian;

(5) Written prior notice to the parents or guardian of the infant or toddler with a disability whenever the state agency or service provider proposes to initiate or change or refuses to initiate or change the identification, evaluation, placement, or provision of appropriate early intervention services to the infant or toddler with a disability;

(6) Procedures designed to assure that the notice required by subdivision (5) of this section fully informs the parents or guardian in the parents' or guardian's native language unless it clearly is not feasible to do so, of all procedures available pursuant to this section; and

(7) During the pendency of any proceeding or action involving a complaint, unless the state agency and the parents or guardian otherwise agree, the child shall continue to receive the appropriate early intervention services currently being provided, or if applying for initial services, shall receive the services not in dispute.

History. Acts 1987, No. 658, § 6; 1997, No. 208, § 17.

A.C.R.C. Notes. Acts 1997, No. 208, § 1, as reenacted by Acts 2017, No. 255, § 1, provided: "Legislative intent and purpose. The General Assembly hereby acknowledges that many of the laws relating to individuals with disabilities are antiquated, functionally outmoded, derogatory, and ambiguous or are inconsistent with more recently enacted provisions of the law. Consequently, it is the intent of the General Assembly and the purpose of

this act to clarify the relevant chapters of Titles 1, 6, 9, 13, 14, 16, 17, 20, 22, 23, and 27 of the Arkansas Code of 1987 Annotated."

U.S. Code. Pub. L. No. 94-142, referred to in this section and known as the Education for All Handicapped Children Act of 1975, was revised and renamed as the Individuals with Disabilities Education Act. For current provisions, see 20 U.S.C. § 1400 et seq.

For Pub. L. No. 99-457, see note, § 20-14-503.

20-14-507. Nonsubstitution of funds — Other benefits not reduced.

(a) Funds provided under the Pub. L. No. 99-457 grant may not be used to satisfy a financial commitment for services which would have been paid for from another public or private source but for the enactment of Pub. L. No. 99-457, except that, whenever considered necessary to prevent the delay in the receipt of appropriate early intervention services by the infant or toddler or family in a timely fashion, funds provided under this subchapter may be used to pay the provider of services pending reimbursement from the agency which has ultimate responsibility for the payment.

(b) Nothing in this subchapter shall be construed to permit the state to reduce medical or other assistance available or to alter eligibility under Title V of the Social Security Act, relating to maternal and child health, or Title XIX of the Social Security Act, relating to Medicaid for infants and toddlers with disabilities, within the state.

History. Acts 1987, No. 658, § 7; 1997, No. 208, § 18.

A.C.R.C. Notes. Acts 1997, No. 208, § 1, as reenacted by Acts 2017, No. 255, § 1, provided: “Legislative intent and purpose. The General Assembly hereby acknowledges that many of the laws relating to individuals with disabilities are antiquated, functionally outmoded, derogatory, and ambiguous or are inconsistent with more recently enacted provisions of the law. Consequently, it is the intent of

the General Assembly and the purpose of this act to clarify the relevant chapters of Titles 1, 6, 9, 13, 14, 16, 17, 20, 22, 23, and 27 of the Arkansas Code of 1987 Annotated.”

U.S. Code. Titles V and XIX of the Social Security Act referred to in this section are codified as 42 U.S.C. § 701 et seq. and 42 U.S.C. § 1396 et seq., respectively. As to Pub. L. No. 99-457, see note, § 20-14-503.

20-14-508. State Interagency Council.

(a)(1) A State Interagency Council composed of at least fifteen (15) members with a maximum of twenty-five (25) members is established.

(2) The council members and the cochair of the council shall be appointed by the Governor for a term of three (3) years. One (1) cochair shall be the parent of a child specified in subdivision (b)(1) of this section. In making appointments to the council, the Governor shall ensure that the membership reasonably represents the population of the state.

(b) The council shall be composed of the following:

(1) At least twenty percent (20%) of the membership shall include parents, including minorities, of infants and toddlers with disabilities, or a child with a disability who is twelve (12) years of age or younger, with knowledge of or experience with programs for infants and toddlers with disabilities, and at least one (1) of the members shall be a parent of a child who is six (6) years of age or under;

(2) At least twenty percent (20%) of the members shall be public or private providers of early intervention services;

(3) At least one (1) member shall be a member of the General Assembly;

(4) At least one (1) member shall be involved in personnel preparation;

(5) At least one (1) member shall be from an agency involved in the provision of or payment for early intervention services to infants and toddlers with disabilities and their families;

(6) At least one (1) member shall be from the state educational agency responsible for preschool services to children with disabilities and shall have sufficient authority to engage in policy planning and implementation on behalf of the agency;

(7) At least one (1) member shall be from the state agency responsible for the Arkansas Medicaid Program;

(8) At least one (1) member shall be a representative from a Head Start agency or similar program in the state;

(9) At least one (1) member shall be a representative from a state agency responsible for child care;

(10) At least one (1) member shall be from the state agency responsible for the regulation of health insurance;

(11) At least one (1) member shall be a representative designated by the Office of Coordinator for Education of Homeless Children and Youths;

(12) At least one (1) member shall be a representative from the state child welfare agency responsible for foster care; and

(13) At least one (1) member shall be a representative from the state agency responsible for children's mental health.

(c) The council shall meet at least quarterly and in those places that it deems necessary. The meetings shall be publicly announced and, to the extent appropriate, open and accessible to the general public.

(d) The council shall:

(1) Advise and assist the lead agency designated in § 20-14-503(b)(9) in the performance of the responsibilities set out in Pub. L. No. 99-457 and in preparation of the budget required, particularly the identification of the sources of fiscal and other support for services for early intervention programs, assignment of financial responsibility to the appropriate agency, and the promotion of the interagency agreements;

(2) Advise and assist the lead agency in the preparation of applications and amendments thereto; and

(3) Prepare and submit an annual report to the Governor and to the United States Secretary of Education on the status of early intervention programs for infants and toddlers with disabilities and their families which are operated within the state.

(e) No member shall cast a vote on any matter which would provide direct financial benefit to that member or otherwise give the appearance of a conflict of interest under state law.

(f) The members shall not receive compensation for their services as members but may receive expense reimbursement in accordance with § 25-16-901 et seq.

History. Acts 1987, No. 658, § 8; 1991, No. 1017, § 3; 1993, No. 937, § 2; 1997, No. 250, §§ 185, 186; 2001, No. 1288, § 17; 2017, No. 540, § 45.

A.C.R.C. Notes. Acts 1987, No. 658, § 8, provided, in part, that a State Interagency Coordinating Council shall be established within three months of the enactment of this law.

Amendments. The 2017 amendment added "for a term of three (3) years" at the end of the first sentence in (a)(2); substituted "one (1)" for "two (2)" in (b)(1); de-

leted "and providers of early intervention services include providers of general day care services in which early intervention services are provided" following "intervention services" in (b)(2); inserted present (b)(3); redesignated former (b)(3) as present (b)(4) and substituted "member shall be" for "person" therein; deleted former (b)(4) and (b)(5); redesignated former (b)(6) as present (b)(5); in present (b)(5), substituted "At least one (1) member shall be from an agency" for "Other members representing each of the appropriate

agencies” and deleted “and others selected by the Governor” following “families”; and added present (b)(6) through (b)(13). **U.S. Code.** As to Pub. L. No. 99-457, see note, § 20-14-503.

SUBCHAPTER 6 — ARCHITECTURAL BARRIERS ACCESSIBILITY

SECTION.
20-14-601 — 20-14-613. [Repealed.]

20-14-601 — 20-14-613. [Repealed.]

Publisher’s Notes. This subchapter, concerning architectural barriers accessibility, was repealed by Acts 1993, No. 876, § 1. The subchapter was derived from the following sources:

20-14-601. Acts 1989, No. 691, § 1.	20-14-605. Acts 1989, No. 691, § 4.
20-14-602. Acts 1989, No. 691, § 2.	20-14-606. Acts 1989, No. 691, § 5.
20-14-603. Acts 1989, No. 691, § 3.	20-14-607. Acts 1989, No. 691, § 5.
20-14-604. Acts 1989, No. 691, § 12.	20-14-608. Acts 1989, No. 691, § 7.
	20-14-609. Acts 1989, No. 691, § 8.
	20-14-610. Acts 1989, No. 691, § 6.
	20-14-611. Acts 1989, No. 691, § 10.
	20-14-612. Acts 1989, No. 691, § 9.
	20-14-613. Acts 1989, No. 691, § 11.

SUBCHAPTER 7 — HEAD INJURIES

SECTION.	SECTION.
20-14-701. Legislative intent.	20-14-704. Rehabilitative services.
20-14-702. Definition.	20-14-705. [Repealed.]
20-14-703. Central registry — Reports.	

20-14-701. Legislative intent.

It is the intent of the General Assembly to ensure that the notification of all head-injured persons be made to the Brain Injury Alliance of Arkansas by appropriate individuals or public and private agencies in order that all persons might obtain the appropriate total rehabilitative services rendered by existing state agencies, departments, and other organizations and individuals.

History. Acts 1989, No. 491, § 1.

20-14-702. Definition.

“Head injury” or “traumatic head injury” means any insult to the brain not of a degenerative or congenital nature, but caused by an external physical force, that may produce a diminished or altered state of consciousness which results in impairment of cognitive abilities or physical functioning. It can also result in the disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial maladjustment.

History. Acts 1989, No. 491, § 1.

20-14-703. Central registry — Reports.

(a) The Brain Injury Alliance of Arkansas is a nonprofit organization devoted entirely to persons who have suffered head injuries. It is an affiliate of the United States Brain Injury Alliance. The alliance shall establish and maintain a central registry of head-injured disabled persons.

(b)(1) Every public and private health and social agency and attending physician shall report to the alliance within five (5) calendar days after an identification of any head-injured disabled person. However, the consent of the individual shall be obtained before making this report, except that every head injury resulting in permanent partial, permanent total, or total disability shall be reported to the alliance immediately upon identification.

(2) The report shall contain the name, age, residence, and type of disability of the individual and such additional information as may be deemed necessary by the alliance.

(3)(A) Within fifteen (15) days of the report and identification of a head-injured person, the alliance shall furnish the Department of Health all available information for use in any information system on injuries maintained by the department.

(B) The alliance shall not release the identity of the patient, reporting physician, or hospital. However, the identity of the patient shall be released upon written consent of the patient or parent or guardian of the patient, the identity of the reporting physician shall be released upon written consent of the reporting physician, and the identity of the hospital shall be released upon written consent of the hospital.

History. Acts 1989, No. 491, § 1.

20-14-704. Rehabilitative services.

(a) Within fifteen (15) days of the report and identification of a head-injured disabled person, the Brain Injury Alliance of Arkansas shall notify the disabled person or the most immediate family members of their right to assistance from the state, the services available, and the eligibility requirements.

(b) The alliance shall refer severely disabled persons to appropriate divisions, departments, and other state agencies to ensure that maximum available rehabilitative services, if desired, are obtained by the head-injured disabled person.

(c) All other agencies of the state shall cooperate with the Governor's Commission on People with Disabilities to ensure that appropriate total rehabilitative and other services are available.

History. Acts 1989, No. 491, § 1.

20-14-705. [Repealed.]

Publisher's Notes. This section, concerning audit of fines, was repealed by Acts 2007, No. 827, § 159. The section was derived from Acts 1989, No. 491, § 1.

SUBCHAPTER 8 — INTERPRETERS BETWEEN HEARING INDIVIDUALS AND INDIVIDUALS WHO ARE DEAF, DEAFBLIND, HARD OF HEARING, OR ORAL DEAF

SECTION.	SECTION.
20-14-801. Findings.	tween Hearing Individuals
20-14-802. Definitions.	and Individuals who are
20-14-803. Penalties.	Deaf, Deafblind, Hard of
20-14-804. Advisory Board for Interpreters between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing, or Oral Deaf — Creation — Membership.	Hearing, or Oral Deaf.
	20-14-806. Powers and duties of Director of Department of Health.
20-14-805. Powers and duties of Advisory Board for Interpreters be-	20-14-807. Licenses.
	20-14-808. Prohibitions.
	20-14-809. Rules.

Effective Dates. Acts 2013, No. 1314, § 5: "Section 20-14-805 is effective on and after November 1, 2013."

20-14-801. Findings.

- (a) The General Assembly finds that:
 - (1)(A) The practice of interpreting affects the public health, safety, and welfare and civic, economic, social, academic, and recreational aspects of life.
 - (B) Therefore, the practice of interpreting should be subject to licensure and regulation to protect the public's interest;
 - (2) Individuals who are deaf, deafblind, hard of hearing, or oral deaf, individuals with disabilities who use special techniques in order to communicate, and individuals whose primary language is sign language have a civil right to effective communication;
 - (3) Individuals with hearing disabilities and those with whom they communicate require and are entitled to competent, reliable interpreting services; and
 - (4) The availability of competent, reliable, credentialed interpreting services is necessary for individuals with hearing disabilities to realize their right to full and equal participation in society.
- (b) The purposes of this subchapter are to:
 - (1) Provide minimum qualifications for interpreters and to ensure that members of the interpreting profession perform with a high degree of competency;

(2) Regulate the practice and licensure of interpreters for individuals who are deaf, deafblind, hard of hearing, or oral deaf; and

(3) Impose penalties for persons who violate this subchapter or the rules adopted under this subchapter.

History. Acts 2013, No. 1314, § 2.

20-14-802. Definitions.

As used in this subchapter:

(1) “Cued speech” means the system of handshapes that represent groups of consonant sounds and hand placements that represent groups of vowel sounds that is used with natural speech to represent a visual model of spoken language;

(2) “Deaf individual” means an individual who has a documented hearing loss so severe that the individual is unable to process speech and language through hearing, with or without amplification;

(3) “Deaf interpreter” means a deaf individual who facilitates communication between another deaf person and a licensed qualified interpreter or between two (2) or more deaf persons;

(4) “Deafblind individual” means an individual who has a combined loss of vision and hearing that prevents the individual’s vision or hearing from being used as a primary source for accessing information;

(5) “Hard of hearing individual” means an individual who has a hearing loss, may primarily use visual communication, and may use assistive devices;

(6) “Interpret” means to provide language equivalency between a hearing individual and an individual who is deaf, deafblind, hard of hearing, or oral deaf using techniques that include without limitation:

(A) American Sign Language;

(B) English-based sign language;

(C) Cued speech; and

(D) Oral interpreting;

(7) “Interpreting agency” means an entity that provides qualified interpreter services for a fee;

(8) “Licensed provisional interpreter” means an individual who is deaf, licensed under this subchapter;

(9) “Licensed qualified interpreter” means an individual licensed under this subchapter;

(10) “Oral deaf individual” means an individual whose sense of hearing is nonfunctional for the purpose of communication and whose primary method of communication is speech reading and spoken English; and

(11) “Oral interpreting” means the use of oral transliteration with special techniques to make the English language visible for persons who communicate as speech readers.

History. Acts 2013, No. 1314, § 2.

20-14-803. Penalties.

(a)(1) A person who is not licensed under this subchapter and who pleads guilty or nolo contendere to or is found guilty of holding himself or herself out to the public as a licensed qualified interpreter is guilty of a violation and shall be fined not less than one hundred dollars (\$100) and not more than five hundred dollars (\$500).

(2) If a person who pleads guilty or nolo contendere to or is found guilty of a violation under subdivision (a)(1) of this section complies with this subchapter within thirty (30) days after pleading guilty or nolo contendere to or being found guilty of a violation under subdivision (a)(1) of this section, the court shall suspend the fine under subdivision (a)(1) of this section.

(b) An interpreting agency that pleads guilty or nolo contendere to or is found guilty of knowingly hiring or providing interpreting services for an individual who is deaf, deafblind, hard of hearing, or oral deaf through an individual not licensed under this subchapter is guilty of a violation and shall be fined not less than five hundred dollars (\$500) and not more than one thousand dollars (\$1,000).

History. Acts 2013, No. 1314, § 2.

20-14-804. Advisory Board for Interpreters between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing, or Oral Deaf — Creation — Membership.

(a) The Advisory Board for Interpreters between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing, or Oral Deaf is created within the Department of Health.

(b) The board shall consist of seven (7) members appointed by the Director of the Department of Health as follows:

(1) Four (4) licensed qualified interpreters appointed from a list of eight (8) submitted by the Arkansas Registry of Interpreters for the Deaf, Inc. in conjunction with the Arkansas Association for the Deaf;

(2) Two (2) members appointed from a list of four (4) submitted by the Arkansas Association for the Deaf in conjunction with the Arkansas Registry of Interpreters for the Deaf, Inc. who are deaf persons, hard of hearing persons, or oral deaf persons not licensed under this subchapter; and

(3) One (1) member appointed from a list of two (2) submitted by the Arkansas Association for the Deaf in conjunction with the Arkansas Registry of Interpreters for the Deaf, Inc. who are neither individuals who are deaf, deafblind, hard of hearing, or oral deaf and who are not licensed under this subchapter.

(c)(1) Each member shall serve a term of three (3) years.

(2) A member shall not serve more than two (2) consecutive terms.

(d) Four (4) members of the board constitute a quorum for the transaction of business of the board.

(e) If a vacancy occurs on the board, the director shall appoint to complete the term vacated a person who possesses the same qualifications as those required for the position to which he or she is appointed.

History. Acts 2013, No. 1314, § 2.

20-14-805. Powers and duties of Advisory Board for Interpreters between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing, or Oral Deaf.

(a) The Advisory Board for Interpreters between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing, or Oral Deaf shall:

(1) Recommend rules for the operation of the Advisory Board for Interpreters between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing, or Oral Deaf to the State Board of Health; and

(2)(A) Hold meetings at the offices of the Department of Health in Little Rock or at other places as the Advisory Board for Interpreters between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing, or Oral Deaf may determine.

(B) The Department of Health shall provide meeting facilities and staff for meetings of the Advisory Board for Interpreters between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing, or Oral Deaf.

(b) The Advisory Board for Interpreters between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing, or Oral Deaf shall review and recommend to the Director of the Department of Health:

(1) Acceptance or rejection of applications for licensure and renewal of licenses for interpreters for the deaf, deafblind, hard of hearing, and oral deaf;

(2) Criteria for issuance and renewal of licenses for licensed qualified interpreters;

(3) Criteria for issuance and continuance of provisional licenses;

(4) Fees for licensure and licensure renewal under this subchapter;

(5) Suspension or revocation of licenses under this subchapter;

(6) Procedures for receiving and investigating complaints under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.;

(7) Rules to ensure that an interpreting agency provides only licensed qualified interpreters for services under this subchapter;

(8) Rules regarding conflicts of interest regarding members of the Advisory Board for Interpreters between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing, or Oral Deaf;

(9)(A) A code of professional conduct.

(B) The code of professional conduct shall provide, at a minimum, that:

(i) A licensed qualified interpreter shall make a true interpretation in an understandable manner to an individual who is deaf, deafblind,

hard of hearing, or oral deaf for whom the licensed qualified interpreter is appointed and that the licensed qualified interpreter will interpret accurately the statements of the individual who is deaf or hard of hearing who desires that his or her statements be made in English to the best of the licensed qualified interpreter's skill and judgment; and

(ii) All information that a licensed qualified interpreter gathers, learns from, or relays to an individual who is deaf, deafblind, hard of hearing, or oral deaf during an administrative, civil, or criminal proceeding shall remain confidential and privileged unless the individual who is deaf, deafblind, hard of hearing, or oral deaf desires that the information be communicated to other persons; and

(10) A continuing education program for licensed qualified interpreters.

History. Acts 2013, No. 1314, § 2.

20-14-806. Powers and duties of Director of Department of Health.

(a) After consideration of the recommendation of the Advisory Board for Interpreters between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing, or Oral Deaf, the Director of the Department of Health shall:

(1) Issue or deny a license or a renewal of license of a licensed qualified interpreter;

(2) Issue or deny a license or a renewal of a licensed provisional interpreter license;

(3) Confirm or overrule a recommendation to revoke or suspend a license for an interpreter between a hearing individual and an individual who is deaf, deafblind, hard of hearing, or oral deaf;

(4) Create and maintain a registry of licensed qualified interpreters; and

(5) Establish reasonable fees for licensure and renewal of licensure.

(b) Before a rule is promulgated under this subchapter, the proposed rule shall be presented to the Legislative Council.

History. Acts 2013, No. 1314, § 2.

Cross References. Review and approval of state agency rules, § 10-3-309.

20-14-807. Licenses.

(a) A licensed qualified interpreter shall meet criteria established under this subchapter for interpreters, including without limitation certification or credentialing by the:

(1) Arkansas Rehabilitation Services Quality Assurance Screening Test;

(2) Educational Interpreter Performance Assessment;

(3) National Association of the Deaf;

- (4) National Cued Speech Association;
- (5) Registry of Interpreters for the Deaf, Inc.; or
- (6) Texas Board for Evaluation of Interpreters.
- (b) A licensed provisional interpreter license may be issued to a deaf interpreter who meets criteria established under this subchapter.
- (c) A license issued under this subchapter is valid for one (1) year.

History. Acts 2013, No. 1314, § 2.

20-14-808. Prohibitions.

- (a) Except as provided in subsection (b) of this section, it is unlawful for an individual to use the title “licensed qualified interpreter” or “licensed provisional interpreter” or to hold himself or herself out as an interpreter between a hearing individual and an individual who is deaf, deafblind, hard of hearing, or oral deaf unless the individual using the title holds a license under this subchapter.
- (b) Subsection (a) of this section does not apply to:
- (1) A person who interprets for an individual who is deaf, deafblind, hard of hearing, or oral deaf during a religious service;
 - (2) A nonresident interpreter who holds a credential or a certificate valid in another state who interprets in Arkansas less than twenty (20) days per year;
 - (3) A person who interprets during an emergency; or
 - (4) A person who is an interpreter intern or a student in training who is:
 - (A) Enrolled in and pursuing a degree in interpreting at an accredited institution of higher education; or
 - (B) Interpreting under the supervision of a licensed qualified interpreter as part of a supervised program of study.

History. Acts 2013, No. 1314, § 2.

20-14-809. Rules.

The State Board of Health shall adopt rules to implement this subchapter.

History. Acts 2013, No. 1314, § 2.

CHAPTER 15

DISEASE AND DISEASE PREVENTION GENERALLY

- SUBCHAPTER.
- 1. GENERAL PROVISIONS. [RESERVED.]
 - 2. CANCER.
 - 3. PHENYLKETONURIA, HYPOTHYROIDISM, AND SICKLE-CELL ANEMIA.
 - 4. REYE’S SYNDROME.
 - 5. SUDDEN INFANT DEATH SYNDROME ACT.
 - 6. RENAL DISEASES.

SUBCHAPTER

7. TUBERCULOSIS.
8. SCOLIOSIS.
9. HUMAN IMMUNODEFICIENCY VIRUS OR ACQUIRED IMMUNODEFICIENCY SYNDROME.
10. BREAST CANCER — MAMMOGRAMS.
11. NEWBORN INFANT HEARING SCREENING PROGRAM.
12. IMMUNIZATION REGISTRATION.
13. BREAST CANCER ACT OF 1997.
14. OSTEOPOROSIS PREVENTION EDUCATION ACT OF 1997.
15. UNIVERSAL NEWBORN HEARING SCREENING, TRACKING, AND INTERVENTION PROGRAM AND ADVISORY BOARD.
16. PROSTATE CANCER ACT OF 1999. [REPEALED.]
17. COLORECTAL CANCER ACT OF 2005. [REPEALED.]
18. ARKANSAS HIV-AIDS MINORITY TASK FORCE ACT OF 2007. [REPEALED.]
19. COLORECTAL CANCER PREVENTION, EARLY DETECTION, AND TREATMENT ACT.
20. DIABETES ACTION PLAN.
21. RIGHT TO TRY ACT.
22. TASK FORCE ON ALPHA-GAL.

RESEARCH REFERENCES

- Am. Jur.** 39 Am. Jur. 2d, Health, § 53 et seq. **C.J.S.** 39A C.J.S., Health & E., § 28 et seq.

SUBCHAPTER 1 — GENERAL PROVISIONS

[Reserved.]

SUBCHAPTER 2 — CANCER

SECTION.

- 20-15-201. Reporting requirements.
 20-15-202. State cancer plan.
 20-15-203. Confidentiality.

SECTION.

- 20-15-204. Agreements with other states.
 20-15-205. Gifts, grants, and donations.
 20-15-206. [Repealed.]

Publisher's Notes. The State Cancer Commission and its powers, duties, and functions were transferred by a Type 3 transfer to the Department of Health by Acts 1971, No. 38, § 11. See § 25-2-106.

Former subchapter 2, concerning cancer, was repealed by Acts 1989, No. 435, § 1. The former subchapter was derived from the following sources:

20-15-201. Acts 1945, No. 277, § 3; A.S.A. 1947, § 82-603.

20-15-202. Acts 1945, No. 277, § 5; A.S.A. 1947, § 82-605.

20-15-203. Acts 1945, No. 277, § 4; A.S.A. 1947, § 82-604.

20-15-204. Acts 1945, No. 277, § 6; A.S.A. 1947, § 82-606.

20-15-205. Acts 1969, No. 222, § 1; A.S.A. 1947, § 82-604.1.

20-15-206. Acts 1985, No. 454, §§ 1-3; A.S.A. 1947, §§ 82-604.2 — 82-604.4.

20-15-201. Reporting requirements.

The Department of Health shall accumulate such data concerning cancer in Arkansas and its residents as is deemed appropriate for the purposes of describing the frequency of cancer, furnishing reports to health professionals and the public, and for planning and evaluating cancer prevention and control programs. The data shall be collected under the authority of regulations promulgated by the State Board of Health.

History. Acts 1989, No. 435, § 2.

20-15-202. State cancer plan.

A task force consisting of public and private entities shall be established by the Director of the Department of Health to assist the Department of Health in developing a strategic plan for a coordinated, comprehensive, statewide network of cancer resources, services, and programs.

History. Acts 1989, No. 435, § 2.

20-15-203. Confidentiality.

Information accumulated and maintained in the Arkansas Central Cancer Registry shall not be divulged except as statistical information which does not identify individuals and for purposes of such research as approved by the State Board of Health.

History. Acts 1989, No. 435, § 2.

20-15-204. Agreements with other states.

(a) The Department of Health may enter into agreements with other states and federal organizations authorized to exchange registry data.

(b) The agreements shall prohibit divulging information to entities without prior approval of the department.

History. Acts 1989, No. 435, § 2.

20-15-205. Gifts, grants, and donations.

The Department of Health may receive gifts, grants, and donations for the purposes of this subchapter.

History. Acts 1989, No. 435, § 2.

20-15-206. [Repealed.]

Publisher's Notes. As to repeal of this section, see note at beginning of subchapter.

SUBCHAPTER 3 — PHENYLKETONURIA, HYPOTHYROIDISM, AND SICKLE-CELL ANEMIA

SECTION.

20-15-301. Injunction.

20-15-302. Testing of newborn infants.

20-15-303. Exception.

SECTION.

20-15-304. Administration by Department of Health.

Cross References. Children with disabilities, educational programs, § 6-41-101 et seq.

Effective Dates. Acts 1967, No. 192, § 7: Mar. 6, 1967. Emergency clause provided: "It is hereby found and determined by the General Assembly that Phenylketonuria is a condition which causes mental illness unless detected and corrective procedures are taken early in the life of a newborn infant, and that the immediate passage of this Act is necessary to authorize the State Board of Health to adopt necessary rules and regulations to require testing of all newborn infants in this State for Phenylketonuria. Therefore, an emergency is hereby declared to exist, and this Act being immediately necessary for the preservation of the public peace, health and safety, shall be in full force and effect from and after its passage and approval."

Acts 1981, No. 481, § 5: Mar. 13, 1981. Emergency clause provided: "It is hereby found and determined by the General Assembly that phenylketonuria and hypothyroidism are conditions which cause irreversible damage unless detected and corrective procedures are taken early in the life of a newborn infant, and that the immediate passage of this Act is necessary to authorize the State Department of Health to adopt necessary rules and regulations to require testing of all newborn infants in this State for phenylketonuria and hypothyroidism. Therefore, an emergency is hereby declared to exist, and this Act being immediately necessary for the preservation of the public peace, health and safety, shall be in full force and effect from and after its passage and approval."

RESEARCH REFERENCES

Ark. L. Rev. Leflar, Liberty and Death: Advance Health Care Directives and the Law of Arkansas, 39 Ark. L. Rev. 375.

20-15-301. Injunction.

The State Board of Health shall have the power to enforce this subchapter by appropriate action for injunction in the circuit courts of this state.

History. Acts 1967, No. 192, § 4; A.S.A. 1947, § 82-628.

20-15-302. Testing of newborn infants.

(a)(1)(A) All newborn infants shall be tested for phenylketonuria, hypothyroidism, galactosemia, cystic fibrosis, and sickle-cell anemia.

(B) In addition, if reliable and efficient testing techniques are available, all newborn infants shall be tested for other genetic

disorders by employing procedures approved by the State Board of Health.

(2)(A) Medicaid shall reimburse the hospital that performs the tests required under subdivision (a)(1) of this section for the cost of the tests.

(B) The reimbursement shall be in addition to the hospital's per diem payments for the newborn infant.

(b) All positive test results shall be sent immediately to the Department of Health.

(c)(1) The department shall establish and maintain a program of reviewing and following up on positive cases so that measures may be taken to prevent intellectual disability or other permanent disabilities.

(2)(A) Information on newborn infants and their families compiled under this section may be used by the department and persons or public or private entities designated by the department.

(B) Information used under subdivision (c)(2)(A) of this section may not refer to or disclose the identity of any person.

(3) All materials, data, and information received by the department are confidential and are not subject to examination or disclosure as public information under the Freedom of Information Act of 1967, § 25-19-101 et seq.

(d)(1) The department shall conduct an intensive educational and training program among physicians, hospitals, public health nurses, and the public concerning the disorders covered under this section.

(2) The program shall include information concerning:

(A) The nature of the disorders;

(B) Testing for the detection of these disorders; and

(C) Treatment modalities for these disorders.

(e) The provisions of this section shall not apply if the parents or legal guardian of a newborn infant object to the testing on medical, religious, or philosophical grounds.

(f) Testing for cystic fibrosis under this section shall be implemented only if funding is available.

History. Acts 1967, No. 192, § 1; 1981, No. 481, § 1; A.S.A. 1947, § 82-625; Acts 1987, No. 573, § 1; 1995, No. 113, § 1; 2003, No. 1293, § 1; 2005, No. 1931, § 1; 2013, No. 428, § 1.

Amendments. The 2013 amendment

deleted "of metabolism" following "disorders" in (a)(1)(B); and substituted "Department of Health" for "Division of Health of the Department of Health and Human Services" in (b).

20-15-303. Exception.

This subchapter shall not apply to any child whose parents or guardian objects thereto on the grounds that it conflicts with the tenets and practices of a recognized church or religious faith of which the parent or guardian is an adherent or member.

History. Acts 1967, No. 192, § 3; A.S.A. 1947, § 82-627.

20-15-304. Administration by Department of Health.

It shall be the duty of the Department of Health to:

- (1) Enforce this subchapter;
- (2) Prescribe the tests that may be administered in compliance with this subchapter;
- (3) Promulgate regulations in conjunction with the Insurance Commissioner establishing:
 - (A) What persons and institutions shall be required to obtain specimens from newborn infants in compliance with this subchapter;
 - (B) The amount to be charged by the central laboratory for processing the specimens; and
 - (C) The method of billing the charges to the persons and institutions;
- (4) Furnish copies of this subchapter and the rules promulgated pursuant to this subchapter to physicians, hospitals, or other institutions or persons required by its regulations to have tests administered to newborn infants;
- (5) Establish a central laboratory and to equip, staff, and operate the laboratory for the purpose of receiving specimens from physicians, hospitals, and institutions, to assure that tests are conducted, and to report findings resulting from the tests;
- (6) Monitor positive test results and assist in treatment and care of affected infants, such follow-up procedures to begin no later than ten (10) days from the time a specimen is diagnosed as positive; and
- (7) Disseminate information and advice to the public concerning the dangers and effects of phenylketonuria, hypothyroidism, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas.

History. Acts 1967, No. 192, § 2; 1981, No. 481, § 2; A.S.A. 1947, § 82-626; Acts 1987, No. 573, § 2; 2003, No. 1293, § 2.

SUBCHAPTER 4 — REYE'S SYNDROME**SECTION.**

20-15-401. Duty of physician to report.

20-15-401. Duty of physician to report.

(a) Every physician practicing medicine in the State of Arkansas shall report to the Department of Health any case or suspected case of Reye's syndrome disease which he or she is attending, or has examined, or for which the physician has prescribed.

(b) The report shall be made as promptly as possible from the time the physician first visits, examines, or prescribes for the patient, and the report shall state the name, age, sex, race, usual residence, place where the patient is to be found, the nature of the disease, the date of

onset, and any additional information that the Director of the Department of Health may require.

(c) The department shall send a copy of the report to the federal Centers for Disease Control and Prevention together with additional information relating thereto as may be required by the Centers for Disease Control and Prevention.

History. Acts 1981, No. 842, § 1; A.S.A. 1947, § 82-643.

SUBCHAPTER 5 — SUDDEN INFANT DEATH SYNDROME ACT

SECTION.
20-15-501. Title.
20-15-502. Reports required.

SECTION.
20-15-503. Autopsy.
20-15-504. Limitation on autopsies.

Publisher's Notes. Acts 1983, No. 718, § 28 provided that the Director of the Department of Health shall allocate sufficient appropriation and funding to comply with the provisions of this subchapter as long as any federal funds are made avail-

able by the United States government to the State of Arkansas which can be used for transporting and performing autopsies on suspected victims of sudden infant death syndrome.

20-15-501. Title.

This subchapter shall be known and may be cited as the “Sudden Infant Death Syndrome Act”.

History. Acts 1979, No. 116, § 1; A.S.A. 1947, § 82-639.

20-15-502. Reports required.

(a) Any sheriff, deputy sheriff, city police officer, state police officer, member of the staff of any public or private hospital, or attending physician with knowledge of the sudden death of a child between the ages of one (1) week and one (1) year who appeared in apparent good health shall immediately report the death to the county coroner or the county sheriff if the county coroner is unavailable, within twenty-four (24) hours after the discovery of the death.

(b) The report shall include facts concerning the time, place, manner, and circumstances surrounding the death.

(c) Upon receipt of the report, the county coroner, or the county sheriff if the county coroner is unavailable, shall report the death to the Department of Health and the Child Abuse Hotline.

History. Acts 1979, No. 116, § 2; A.S.A. 1947, § 82-640; Acts 2015, No. 1211, § 5.

Amendments. The 2015 amendment added “and the Child Abuse Hotline” in

(c).

20-15-503. Autopsy.

(a) Upon receipt of the report, the county coroner, or the county sheriff if the county coroner is unavailable, shall request from the parents or guardian of the deceased written permission upon a form provided by the Department of Health for an autopsy to be made to determine the exact cause of death.

(b)(1) Upon receipt of the permission, the county coroner, or the county sheriff if the county coroner is unavailable, shall notify the department. The department shall arrange for the transportation of the deceased and arrange for an autopsy to be made by a licensed physician in the State of Arkansas and shall arrange for the return transportation of the deceased.

(2) If the parents or guardian shall refuse permission for an autopsy to be made, the death nevertheless shall be reported to the department.

(c)(1) The results and findings of the autopsy, if any is performed, shall be reported to the parents or guardian of the deceased.

(2) The appropriate finding of cause of death shall be recorded upon the certificate of death in any case and the term “sudden infant death syndrome” shall be entered on the certificate of death when it is appropriately descriptive of the circumstances and cause of death of the child.

(d) Information concerning sudden infant death syndrome shall be provided by the department to the parents or guardian of an infant whose death has been reported pursuant to this subchapter.

History. Acts 1979, No. 116, § 3; A.S.A. 1947, § 82-641.

20-15-504. Limitation on autopsies.

The Department of Health shall provide for the transportation and the autopsy as provided in § 20-15-503 only so long as federal funds are available to the department for the transportation and autopsies of suspected victims of sudden infant death syndrome.

History. Acts 1979, No. 116, § 4; A.S.A. 1947, § 82-642.

SUBCHAPTER 6 — RENAL DISEASES

SECTION.

- 20-15-601. Legislative findings and purpose.
- 20-15-602. State Kidney Disease Commission — Creation —

SECTION.

- Members.
- 20-15-603. State Kidney Disease Commission — Powers and duties.

SECTION.

20-15-604. State Kidney Disease Commission — Advisory association.

SECTION.

20-15-605. State Kidney Disease Commission — Disbursement of funds.

Effective Dates. Acts 1971, No. 450, § 9: Mar. 30, 1971. Emergency clause provided: "It is hereby found and determined by the General Assembly that a number of citizens of this State are suffering from chronic renal disease and face death unless immediate steps are taken to provide a system of financial assistance to enable such persons to obtain care and treatment of such chronic renal disease; and that the immediate passage of this Act is necessary in order to establish a state program of providing assistance for the care and treatment of such individuals which is essential to saving their lives and permitting them to live as productive citizens; and the General Assembly further determines that additional delay in the implementation of this program will result in the unnecessary loss of lives that could be saved through a program of financial assistance provided by this Act. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Identical Acts 1983, Nos. 131 and 135, § 6: Feb. 10, 1983. Emergency clauses provided: "It is hereby found and determined by the General Assembly that state boards and commissions exist for the singular purpose of protecting the public health and welfare; that citizens over 60 years of age represent a significant percentage of the population; that it is necessary and proper that the older population be represented on such boards and commissions; that the operations of the boards and commissions have a profound effect on the daily lives of older Arkansas; and that the public voice of older citizens should not be muted as to questions coming before such bodies. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1987, No. 1050, § 13: July 1, 1987. Emergency clause provided: "It is hereby

found and determined by the Seventy-Sixth General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness of this Act on July 1, 1987 is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1, 1987 could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 1987."

Acts 1989 (1st Ex. Sess.), No. 202, § 13: July 1, 1989. Emergency clause provided: "It is hereby found and determined by the Seventy-Seventh General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness of this Act on July 1, 1989 is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1, 1989 could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 1989."

Acts 1997, No. 250, § 258: Feb. 24, 1997. Emergency clause provided: "It is hereby found and determined by the General Assembly that Act 1211 of 1995 established the procedure for all state boards and commissions to follow regarding reimbursement of expenses and stipends for board members; that this act amends various sections of the Arkansas Code

which are in conflict with the Act 1211 of 1995; and that until this cleanup act becomes effective conflicting laws will exist. Therefore an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the

Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

20-15-601. Legislative findings and purpose.

(a)(1) It is declared and found that one (1) of the major problems facing medicine and the public health and welfare is the lack of an adequate program to assist in the treatment and cure of persons suffering from chronic kidney disease.

(2) It is estimated that a number of citizens of this state annually are confronted with chronic kidney disease requiring complicated and expensive treatment which is often beyond the financial resources of the individuals.

(3) There is a critical shortage of adequate facilities within the state for the discovery, evaluation, diagnosis, treatment, and cure of individuals suffering from chronic kidney disease.

(b) In order to provide for the care and treatment of persons suffering from acute or chronic kidney disease and in order to encourage and assist in the development of adequate treatment facilities for persons suffering from acute or chronic kidney disease, it is essential that the state develop a program of financial assistance to aid in defraying a portion of the cost for the care and treatment of chronic kidney disease to the extent that the individual suffering from the disease is unable to pay for the services on a continuing basis.

History. Acts 1971, No. 450, § 1; A.S.A. 1947, § 82-2501.

20-15-602. State Kidney Disease Commission — Creation — Members.

(a)(1) There is established a State Kidney Disease Commission to consist of ten (10) members.

(2) Nine (9) members shall be appointed by the Governor and confirmed by the Senate as follows:

(A) Three (3) members who are knowledgeable in renal medicine and the treatment of end-stage renal disease shall be physicians licensed to practice in Arkansas who are actively engaged in the private practice of medicine in this state;

(B) One (1) member who is knowledgeable in renal medicine and the treatment of end-stage renal disease shall be a physician licensed in Arkansas who is engaged primarily in the institutional practice of medicine;

(C) Two (2) members shall be persons engaged in hospital administrative activities;

(D) Two (2) members shall be named from the public at large, but they shall be individuals who have a demonstrated interest in the treatment and cure of renal diseases; and

(E) One (1) member who shall represent the elderly shall be sixty (60) years of age or older and shall be appointed from the state at large. The member shall not be actively engaged in or retired from any profession, occupation, or industry which is regulated pursuant to this subchapter.

(3) The Commissioner of the Arkansas Rehabilitation Services of the Department of Career Education shall be a member of the commission and shall serve as secretary and disbursing officer of funds appropriated to the commission for the treatment and cure of renal diseases.

(b) Members shall be appointed for four-year terms to expire on January 14 of the members' fourth year of the appointed term. Members shall serve until their successors are appointed and qualified.

(c) If a vacancy occurs on the commission due to death, resignation, or other cause, the vacancy shall be filled by appointment of the Governor of a person eligible for the initial appointment, as provided in subsection (a) of this section, for the remainder of the unexpired portion of the term of the member.

(d) The commission shall annually elect one (1) of its members as chair and one (1) of its members as vice chair and such other officers as the commission deems necessary.

(e) The commission shall meet at least one (1) time each calendar quarter and at such other times as may be designated by the commission's rules or upon call by the Chair of the State Kidney Disease Commission or upon written request of any four (4) members.

(f) Members shall serve without pay but may receive expense reimbursement in accordance with § 25-16-901 et seq.

(g) Members shall qualify by taking the oath of office as prescribed by law.

History. Acts 1971, No. 450, §§ 2, 3; 1983, No. 131, §§ 1-3, 5; 1983, No. 135, §§ 1-3, 5; A.S.A. 1947, §§ 6-623 — 6-626, 82-2502, 82-2503; Acts 1991, No. 848, § 1; 1997, No. 250, § 187.

Publisher's Notes. The terms of the members of the State Kidney Disease

Commission, other than the term of the member who represents the elderly, are arranged so that the term of one of each of the two members named to represent each of the groups designated in subdivisions (a)(2)(A)-(D) expired every two years.

20-15-603. State Kidney Disease Commission — Powers and duties.

(a) The State Kidney Disease Commission shall have the following functions, powers, and duties:

(1)(A)(i) To establish a program to assist persons suffering from acute or chronic renal failure in obtaining care and treatment requiring kidney dialysis or transplantation.

(ii) Services to assist persons requiring transplantation may include dental services necessary for consideration for transplantation and the copayment of immunosuppressant drugs post transplantation.

(B) The program shall provide financial assistance for persons suffering from chronic renal diseases who require life-saving care and treatment for the renal disease to the extent as determined by the commission that a person is unable to pay for the services on a continuing basis without causing unjust and unusual hardship to himself or herself and his or her immediate family including without limitation a drastic lowering of the standard of living;

(2) To develop standards for determining eligibility for assistance in defraying the cost of care and treatment of renal disease under this program;

(3) To cooperate with hospitals, private groups, and organizations and public agencies in the development of positive programs to bring about financial assistance and support of evaluation and treatment of patients suffering from chronic kidney disease;

(4) To cooperate with the national and state kidney foundations and with medical programs of the state and the United States Government for the purpose of obtaining the maximum amount of federal and private assistance possible in support of a kidney disease treatment program;

(5) To establish criteria and standards for evaluating the financial ability of persons suffering from chronic kidney disease to pay for their own care, including the availability of third-party insurance coverage, for the purpose of establishing standards for eligibility for financial assistance in defraying the cost of the care and treatment from funds appropriated to the commission for renal disease treatment purposes;

(6) To accept gifts, grants, and donations from private sources and the United States Government and support from municipal and county governments to be used for the purposes of this subchapter in defraying costs incurred by persons suffering from acute or chronic renal disease who are unable to meet the total cost of life-saving care and treatment for renal disease; and

(7) To accept gifts, grants, and donations from private sources and the United States Government and support from municipal and county governments to be used to honor persons who have provided living kidney donations to Arkansans in need of kidney transplantation.

(b) Whereas the current Department of Finance and Administration accounting system will accept current-year refunds, credit the current-year appropriation, and allow expenditure of the funds, the commission, administered by the Arkansas Rehabilitation Services, may accept prior-year refunds and contributions and deposit the funds into the agency cash fund in an account specifically identified as the State Kidney Disease Escrow Account and disbursed for the purchase of additional services for clients served by the commission.

History. Acts 1971, No. 450, § 4; A.S.A. 1947, § 82-2504; Acts 1987, No. 1050, § 9; 1989 (1st Ex. Sess.), No. 202, § 8; 2011, No. 268, § 1; 2015, No. 1029, § 1.

Amendments. The 2015 amendment

redesignated (a)(1)(A) as (a)(1)(A)(i); substituted “kidney dialysis or transplantation” for “dialysis” at the end of (a)(1)(A)(i); and added (a)(1)(A)(ii).

20-15-604. State Kidney Disease Commission — Advisory association.

(a) In developing rules and regulations and in determining standards for determining eligibility for financial assistance to persons suffering from chronic renal diseases who require lifesaving care and treatment for such renal diseases, the State Kidney Disease Commission shall consult with and obtain the advice of the Arkansas Association for Kidney Disease, Inc., a nonprofit corporation organized under the laws of this state. This organization is recognized as the representative body to serve as an advisory association to the commission and to the deputy director of the appropriate division as determined by the Director of the Department of Health in carrying out their functions and duties under this subchapter.

(b) Before promulgating rules and regulations and eligibility standards, the commission shall consult with the advisory association and shall give consideration to its recommendations in performing its duties under the provisions of this subchapter.

History. Acts 1971, No. 450, § 5; A.S.A. 1947, § 82-2505.

20-15-605. State Kidney Disease Commission — Disbursement of funds.

(a) The Commissioner of the Arkansas Rehabilitation Services of the Department of Career Education shall be the disbursing officer of funds appropriated by the General Assembly and of other funds made available to the State Kidney Disease Commission for such purposes. These funds are to provide monetary assistance to defray the cost incurred by patients suffering from acute or chronic renal disease who are unable to meet the total cost of their care or treatment from their own resources or from third-party resources.

(b) The commissioner shall be governed by the policies, rules and regulations, and procedures promulgated by the commission in disbursing funds appropriated, or otherwise made available, to the commission for renal disease treatment purposes.

History. Acts 1971, No. 450, § 6; A.S.A. 1947, § 82-2506; Acts 1991, No. 848, § 2.

Cross References. Prior-year re-funds, § 20-15-603(b).

SUBCHAPTER 7 — TUBERCULOSIS

SECTION.

- 20-15-701. Definition.
- 20-15-702. Penalty.
- 20-15-703. Involuntary examinations.
- 20-15-704. Petition to isolate patient.
- 20-15-705. Notice of petition and hearing.
- 20-15-706. Hearing.

SECTION.

- 20-15-707. Commitment.
- 20-15-708. Observation of rules and regulations required.
- 20-15-709. Discharge.
- 20-15-710. Violations of commitment — Penalties.

Effective Dates. Acts 1957, No. 298, § 2: Mar. 27, 1957. Emergency clause provided: "It is hereby determined as a matter of fact that the failure to authorize the City Health Officer to function in accomplishing the purposes sought under Act

161 of 1955 has resulted in an impairment of the public peace, health and safety and an emergency is declared to exist, and this act shall take effect from and after its passage."

CASE NOTES

ANALYSIS

Construction.
Appeal.
Parens Patriae.

Construction.

Although this subchapter is not a penal statute, it is to be strictly construed to protect the rights of the citizen. *State v. Snow*, 230 Ark. 746, 324 S.W.2d 532 (1959).

Appeal.

Appeals under this subchapter are tested in the same way as chancery ap-

peals are tested and Supreme Court will examine the evidence to ascertain if the findings of the probate judge are against the preponderance of the evidence. *State v. Snow*, 230 Ark. 746, 324 S.W.2d 532 (1959).

Parens Patriae.

A proceeding under this subchapter is neither a civil nor a criminal proceeding but a special proceeding by the state in its character of parens patriae based on the theory that the public has an interest to be protected. *State v. Snow*, 230 Ark. 746, 324 S.W.2d 532 (1959).

20-15-701. Definition.

As used in this subchapter, "active tuberculosis" means that the disease is in a communicable or infectious stage as established by chest X ray, microscopical examination of sputum, or other diagnostic procedures approved jointly by the Director of the Department of Health and the medical director of either the Arkansas Tuberculosis Sanatorium or the Arkansas State Hospital.

History. Acts 1955, No. 161, § 1; A.S.A. 1947, § 82-611.

20-15-702. Penalty.

Any person who violates any of the provisions of this subchapter shall be guilty of a violation and upon conviction shall pay a fine of not less

than twenty-five dollars (\$25.00) and not more than one hundred dollars (\$100).

History. Acts 1955, No. 161, § 14; A.S.A. 1947, § 82-624; Acts 2005, No. 1994, § 189.

CASE NOTES

Cited: State v. Snow, 230 Ark. 746, 324 S.W.2d 532 (1959).

20-15-703. Involuntary examinations.

(a) When the state, county, or city health officer shall have reasonable grounds to believe that any person has tuberculosis in an active state or in a communicable form and who will not voluntarily seek a medical examination or treatment, the health officer may cause the person to be apprehended and detained for the necessary tests and examinations, including an approved chest X ray, sputum examination, and other approved laboratory tests to ascertain the existence of tuberculosis.

(b) If active tuberculosis is found to exist, it shall then be the duty of the health officer to make an investigation of the person to determine whether the environmental conditions of the person or the conduct of the person is suitable for proper isolation or control of the case by any type of local quarantine.

History. Acts 1955, No. 161, § 2; 1957, No. 298, § 1; 1961, No. 171, § 1; A.S.A. 1947, § 82-612.

CASE NOTES

Cited: Powell v. Woolfolk, 233 Ark. 893, 349 S.W.2d 657 (1961).

20-15-704. Petition to isolate patient.

(a) If the health officer finds that the circumstances are not suitable for proper isolation or contagious control of the case by any type of local quarantine and if the person will not voluntarily seek medical treatment and is a source of danger to others, then the health officer shall petition the circuit court of the county where the person is found to order the admission of the person to any state-owned and state-operated hospital or sanatorium or any other hospital or sanatorium that is equipped to treat tuberculosis under the conditions enumerated in § 20-15-707(a).

(b) The health officer shall set forth in a petition a summary of the factual basis of the determination that the circumstances are not suitable for proper isolation or contagious control of the case by any

type of local quarantine and that the person will not voluntarily seek medical treatment and is a source of danger to others.

History. Acts 1955, No. 161, §§ 3, 4; 1975, No. 745, § 1; A.S.A. 1947, §§ 82-613, 82-614.

CASE NOTES

Cited: Powell v. Woolfolk, 233 Ark. 893, 349 S.W.2d 657 (1961).

20-15-705. Notice of petition and hearing.

(a) Upon receiving the petition, the court shall fix a date for a hearing on the petition and shall cause notice of the petition, with the time and place for the hearing, to be served personally at least seven (7) days before the hearing upon the person who has tuberculosis and is alleged to be dangerous to others.

(b) While the petition is pending, the person shall be subject to the local quarantine or restrictions of his or her movements placed on him or her by the health officer for the protection of the public health.

History. Acts 1955, No. 161, § 5; A.S.A. 1947, § 82-615; Acts 1997, No. 208, § 19.

A.C.R.C. Notes. Acts 1997, No. 208, § 1, as reenacted by Acts 2017, No. 255, § 1, provided: "Legislative intent and purpose. The General Assembly hereby acknowledges that many of the laws relating to individuals with disabilities are antiquated, functionally outmoded, de-

rogatory, and ambiguous or are inconsistent with more recently enacted provisions of the law. Consequently, it is the intent of the General Assembly and the purpose of this act to clarify the relevant chapters of Titles 1, 6, 9, 13, 14, 16, 17, 20, 22, 23, and 27 of the Arkansas Code of 1987 Annotated."

CASE NOTES

Cited: State v. Snow, 230 Ark. 746, 324 S.W.2d 532 (1959).

20-15-706. Hearing.

The petition shall be heard in open court, and the respondent to the petition shall have the privilege of counsel of his or her own selection.

History. Acts 1955, No. 161, § 6; A.S.A. 1947, § 82-616.

CASE NOTES

Cited: State v. Snow, 230 Ark. 746, 324 S.W.2d 532 (1959).

20-15-707. Commitment.

- (a) If upon hearing of the petition the court finds that the circumstances are not suitable for proper isolation or contagious control of the case by any type of local quarantine and that the person will not voluntarily seek medical treatment and is a source of danger to others, the court shall order the commitment of the person to a hospital or sanatorium as petitioned for.
- (b) The superintendent of the institution to which the person is committed shall direct that the person be placed apart from others and restrained from leaving the institution.

History. Acts 1955, No. 161, §§ 7, 8;
A.S.A. 1947, §§ 82-617, 82-618.

CASE NOTES

<p>Evidence. Evidence sufficient to show lower court properly refused to commit defendant, but action was not res judicata and case would be remanded for further proceedings.</p>	<p>State v. Snow, 230 Ark. 746, 324 S.W.2d 532 (1959). Cited: Powell v. Woolfolk, 233 Ark. 893, 349 S.W.2d 657 (1961).</p>
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20-15-708. Observation of rules and regulations required.

- (a) A person who is committed to the hospital or sanatorium under the provisions of this subchapter shall observe all the rules and regulations of the hospital or sanatorium.
- (b) The superintendent of the institution may file a complaint in the district court against a person committed to the institution under the provisions of this subchapter who willfully violates the rules and regulations of the institution or who conducts himself or herself in a disorderly manner. A person so charged shall have the legal procedural rights of a person charged with disorderly conduct.

History. Acts 1955, No. 161, §§ 9, 10;
A.S.A. 1947, §§ 82-619, 82-620; Acts 2003,
No. 1185, § 255.

CASE NOTES

Cited: State v. Snow, 230 Ark. 746, 324 S.W.2d 532 (1959).

20-15-709. Discharge.

- (a) The superintendent of the institution to which a person has been committed under this subchapter may discharge the person so committed upon signing and placing among the records of the institution a statement that the person has obeyed the rules and regulations of the institution and that for the reasons set forth in the statement, in his or

her judgment the person may be discharged without danger to the health and life of others.

(b) The superintendent of the institution shall report each discharge with a full statement of reasons therefor at once to the Director of the Department of Health, to the county health officer of the county where the person was committed, and to the clerk of the court from which the person was committed.

History. Acts 1955, No. 161, §§ 12, 13;
A.S.A. 1947, §§ 82-622, 82-623.

CASE NOTES

Cited: State v. Snow, 230 Ark. 746, 324
S.W.2d 532 (1959).

20-15-710. Violations of commitment — Penalties.

(a) A person committed to an institution who is found guilty of violating the rules and regulations of the institution or of conducting himself or herself in a disorderly manner may be confined for a period not to exceed six (6) months in any place where persons convicted of disorderly conduct may be confined.

(b) Any person committed to an institution pursuant to this subchapter, who shall leave or attempt to leave the institution without being properly discharged by the superintendent of the institution or his or her authorized agent, shall be guilty of a misdemeanor and upon conviction shall be imprisoned for a period of not less than six (6) months nor more than one (1) year.

(c) Any person confined or imprisoned pursuant to this section shall be kept separate from the other inmates of the place of confinement. Upon completion of the period of confinement, he or she shall be returned to the hospital or sanatorium where originally committed.

(d) Any person confined or imprisoned pursuant to the provisions of this section may be confined or imprisoned in the hospital or sanatorium where originally committed if facilities for confinement or imprisonment are available at the hospital or sanatorium.

History. Acts 1955, No. 161, § 11;
1963, No. 174, § 1; A.S.A. 1947, § 82-621.

CASE NOTES

Cited: State v. Snow, 230 Ark. 746, 324
S.W.2d 532 (1959).

SUBCHAPTER 8 — SCOLIOSIS

SECTION.

20-15-801. Legislative determination.

20-15-802. Screening program.

SECTION.

20-15-803. Regulations.

Effective Dates. Acts 1987, No. 41, § 3; Feb. 16, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that scoliosis attacks children in their developing years; that it is relatively easy to conduct a scoliosis screening program and thereby detect the spinal curvature as soon as possible and begin treatment at the earliest stages of the disease; that the scoliosis screening program should commence as soon as possible; that it is necessary for the State Board of Health to promulgate regulations establishing the detailed pro-

cedures for conducting the scoliosis screening program; that the regulations should be promulgated as soon as possible in order to assure that the screening program can be implemented as soon as possible; and that this Act is immediately necessary to grant the Board of Health the authority to commence promulgating those regulations. Therefore, an emergency is hereby declared to exist and this Act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

20-15-801. Legislative determination.

(a) The General Assembly recognizes that scoliosis is a terrible disease of the spine which attacks young children during their formative years and that the spinal curvature can be relatively easily detected and should be treated as early as possible.

(b) The General Assembly has determined that the most logical entities to conduct a scoliosis screening program are our private schools, public schools, and other state-supported institutions providing education to our children.

History. Acts 1987, No. 41, § 1; 1989, No. 95, § 1.

20-15-802. Screening program.

Every public elementary and secondary school in this state, every other institution supported by state funds which provides education to our minor children, and all private institutions which provide education to our minor children shall as soon as possible institute a continuing scoliosis screening program to be conducted in accordance with regulations promulgated by the State Board of Health.

History. Acts 1987, No. 41, § 1; 1989, No. 95, § 2.

20-15-803. Regulations.

(a) The State Board of Health is directed to promulgate regulations as soon as possible to implement this subchapter.

(b) The regulations shall not be effective until concurred in by the State Board of Education.

(c) The regulations shall provide that no child shall be screened if his or her parent or guardian objects to the screening in writing, stating as the basis of the objection that it is contrary to the parent's or guardian's religious beliefs.

(d) The regulations shall provide that the schools shall not be required to hire personnel on a full-time, part-time, or consultant basis to conduct the screening, but they shall utilize school health personnel, volunteers, and other school employees who are not classroom teachers and who meet the qualifications prescribed by the regulations.

History. Acts 1987, No. 41, § 1.

SUBCHAPTER 9 — HUMAN IMMUNODEFICIENCY VIRUS OR ACQUIRED IMMUNODEFICIENCY SYNDROME

SECTION.

- 20-15-901. Free testing program — Confidentiality.
- 20-15-902. Counseling — Seminars.
- 20-15-903. Advising physician or dentist required — Penalty.
- 20-15-904. Reporting — Confidentiality — Subpoenas.
- 20-15-905. HIV Shield Law — Definitions.

SECTION.

- 20-15-906. Report to the Department of Health required — Privileged communications.
- 20-15-907. Title.
- 20-15-908. Findings and purpose.
- 20-15-909. Implementation.

Effective Dates. Acts 1989, No. 614, § 8: Mar. 16, 1989. Emergency clause provided: "It is hereby found and determined by the General Assembly that a person with Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) antigen or antibodies who acts irresponsibly with respect to sexual contact or with respect to transfer of blood or blood products constitutes a deadly threat to the public and health and welfare of the people of the state of Arkansas; that the incidence of Acquired Immunodeficiency Syndrome (AIDS) is increasing at an alarming rate and that Acquired Immunodeficiency Syndrome (AIDS) results in enormous social, health and economic costs, ultimately causing premature death of all those infected with Human Immunodeficiency Virus (HIV). Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1991, No. 289, § 9: Feb. 28, 1991. Emergency clause provided: "It is hereby found and determined by the Seventy-Eighth General Assembly of the State of Arkansas that health care providers require early information relating to the

HIV status of patients when a physician determines that obtaining and providing such information is medically indicated; that such information is necessary to protect the public health from the spread of HIV; and that this act should go into effect immediately in order to better protect the public health from HIV infection. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force from and after its passage and approval."

Acts 1992 (1st Ex. Sess.), No. 72, § 9: Mar. 20, 1992. Emergency clause provided: "It is hereby found and determined by the General Assembly that certain provisions of the Arkansas Code concerning payment of covered services are confusing and misleading and could cause irreparable harm to citizens of Arkansas. Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety the provisions of this Act shall be in full force and effect from and after its passage and approval."

Acts 2001, No. 235, § 4: Feb. 13, 2001. Emergency clause provided: "It is hereby found and determined by the Eighty-third General Assembly that there is a pressing

and immediate need for the distribution of medications for HIV/AIDS to alleviate suffering, to protect pregnant women with HIV/AIDS and their unborn children and to prevent severe damage to the medical infrastructure of Arkansas. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of

its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto.”

RESEARCH REFERENCES

ALR. Discovery of identity of blood donors. 56 A.L.R.4th 755.
AIDS infection as affecting right to attend school. 60 A.L.R.4th 15.

Child custody and visitation rights of person infected with AIDS. 86 A.L.R.4th 211.
C.J.S. 39A C.J.S., Health & E., § 30.

20-15-901. Free testing program — Confidentiality.

- (a) The Department of Health shall institute an acquired immune deficiency syndrome (AIDS) testing program whereby any citizen may be tested for the virus without charge.
- (b) The program shall be so devised as to maintain secrecy as to the identification of persons voluntarily participating in the program.

History. Acts 1987 (1st Ex. Sess.), No. 51, § 1.

20-15-902. Counseling — Seminars.

The Department of Education, the University of Arkansas for Medical Sciences, and the Department of Health shall jointly provide counseling and shall also conduct public seminars designed to educate the public regarding acquired immune deficiency syndrome (AIDS).

History. Acts 1987 (1st Ex. Sess.), No. 51, § 2.

20-15-903. Advising physician or dentist required — Penalty.

- (a) Before receiving any healthcare services of a physician or dentist, any person who is found to have human immunodeficiency virus (HIV) infection shall advise the physician or dentist that the person has human immunodeficiency virus (HIV) infection.
- (b) Any person failing or refusing to comply with the provisions of subsection (a) of this section shall be guilty of a Class A misdemeanor and punished accordingly.

History. Acts 1989, No. 413, §§ 1, 2.

20-15-904. Reporting — Confidentiality — Subpoenas.

(a) A person with acquired immunodeficiency syndrome (AIDS) or who tests positive for the presence of human immunodeficiency virus (HIV) antigen or antibodies is infectious to others through the exchange of body fluids during sexual intercourse and through the parenteral transfer of blood or blood products and under these circumstances is a danger to the public.

(b) A physician whose patient is determined to have acquired immunodeficiency syndrome (AIDS) or who tests positive for the presence of human immunodeficiency virus (HIV) antigen or antibodies shall immediately make a report to the Department of Health in the manner and form as the department shall direct.

(c)(1) All information and reports in connection with persons suffering from or suspected to be suffering from the diseases specified in this section shall be regarded as confidential by every person, body, or committee whose duty it is or may be to obtain, make, transmit, and receive information and reports.

(2) However, any prosecuting attorney of this state may subpoena information as may be necessary to enforce the provisions of this section and §§ 5-14-123 and 16-82-101, provided that any information acquired pursuant to the subpoena shall not be disclosed except to the courts to enforce this section.

History. Acts 1989, No. 614, §§ 1, 3, 4. § 1, is also codified as §§ 5-14-123(a) and
Publisher's Notes. Acts 1989, No. 614, 16-82-101(a).

RESEARCH REFERENCES

U. Ark. Little Rock L.J. Survey,
Criminal Law, 12 U. Ark. Little Rock L.J.
617.

CASE NOTES

Cited: Weaver v. State, 66 Ark. App.
249, 990 S.W.2d 572.

20-15-905. HIV Shield Law — Definitions.

(a) As used in this section:

(1) "Healthcare provider" means any physician, nurse, paramedic, or other person providing medical, nursing, or other healthcare services of any kind;

(2) "Health facility" means a hospital, nursing home, blood bank, blood center, sperm bank, or other healthcare institution;

(3) "HIV" means the human immunodeficiency virus or any other identified causative agent of acquired immunodeficiency syndrome (AIDS);

(4) "Person" includes any natural person, partnership, association, joint venture, trust, governmental entity, public or private corporation, health facility, or other legal entity; and

(5) "Test" or "HIV test" means a test to determine the presence of the antibody or antigen to HIV or of HIV infection.

(b)(1) Consent is not required for a healthcare provider or health facility to perform a test when a healthcare provider or employee of a health facility is involved in a direct skin or mucous membrane contact with the blood or bodily fluids of an individual which is of a nature that may transmit HIV, as determined by a physician in his or her medical judgment.

(2)(A) The results of the test shall be provided by the person ordering the test to the affected healthcare provider or employee of a health facility, to the healthcare provider's or employee's physician, to the individual tested, and to the individual's physician.

(B) Appropriate counseling shall be provided along with the test results.

(c)(1) Informed consent, information, and counseling are not required for the performance of an HIV test when, in the judgment of the physician, the testing is medically indicated to provide an appropriate diagnosis and treatment to the subject of the test, provided that the subject of the test has otherwise provided his or her consent to the physician for medical treatment.

(2) If confirmatory testing is positive for evidence of HIV infection, the patient shall be informed.

(d) Healthcare providers or facilities may not deny appropriate care based upon the results of an HIV test.

(e)(1) Notwithstanding any other law to the contrary, no person who performs a test pursuant to subsection (b) or subsection (c) of this section shall be subject to civil or criminal liability for doing so.

(2) Notwithstanding any other law to the contrary, no person who discloses a test result in accordance with the provisions of subsection (b) of this section shall be subject to civil or criminal liability. However, nothing in this section shall be construed to limit the confidentiality for AIDS testing provided by § 20-15-901 or other provision of law unless testing is conducted pursuant to this section.

History. Acts 1991, No. 289, §§ 1-5;
1999, No. 1536, § 11.

CASE NOTES

Criminal Trial.

Health Insurance Portability and Accountability Act of 1996 does not limit a state's authority to investigate crimes; therefore, there was no error committed

by the prosecution's decision to subpoena a nurse practitioner to testify that defendant had tested positive for the human immunodeficiency virus. *White v. State*, 370 Ark. 284, 259 S.W.3d 410 (2007).

20-15-906. Report to the Department of Health required — Privileged communications.

(a) Reports shall be made to the Department of Health in the form and manner as may be required by the department for all persons who have been determined to have acquired immunodeficiency syndrome or who have tested positive for the presence of human immunodeficiency virus antigen or antibodies.

(b) Reporting is required by the following persons:

(1) Physicians;

(2) Hospital infection control practitioners and the chairs of hospital infection control committees;

(3) Directors of laboratories doing business in the State of Arkansas;

(4) Medical directors of in-home health agencies;

(5) Program directors of state agencies to whom a human immunodeficiency virus or acquired immunodeficiency syndrome diagnosis has been disclosed;

(6) Nursing home medical directors; and

(7) Those other persons as are required by the rules and regulations of the department.

(c) Notwithstanding this section or any other law, the privileged communications provisions under §§ 17-103-107 and 17-103-108 are not repealed.

History. Acts 1991, No. 967, §§ 1, 2; 1992 (1st Ex. Sess.), No. 72, § 5; 1999, No. 1122, § 6.

20-15-907. Title.

This section and §§ 20-15-908 and 20-15-909 shall be known and may be cited as the “Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) Medications Act of 2001”.

History. Acts 2001, No. 235, § 1.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of Public Health and Welfare, 24 U. Legislation, 2001 Arkansas General Assembly, Public Health and Welfare, 24 U. Ark. Little Rock L. Rev. 557.

20-15-908. Findings and purpose.

It is found and determined by the General Assembly that:

(1) The citizens of Arkansas suffering from human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) should have access to the latest drug therapies;

(2) The continued spread of human immunodeficiency virus (HIV) is a danger to the public health of Arkansas;

(3) Proper treatment of individuals living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) who

are pregnant can significantly decrease the possibility of infecting their unborn children;

(4) Infection rates among Arkansas citizens can be curtailed by the proper administration of drug therapies to those infected with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS);

(5) The continued medical costs associated with illnesses related to human immunodeficiency virus (HIV) are a threat to the medical infrastructure of Arkansas;

(6) The quality of life of those individuals affected by human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), along with the quality of life of their family members, can be enhanced through continuing drug therapies;

(7) There is a pressing and immediate need for the distribution of medications for human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS); and

(8) This section and §§ 20-15-907 and 20-15-909 can help meet these needs by furnishing financial assistance, subject to the availability of funds, to citizens of Arkansas suffering from human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS).

History. Acts 2001, No. 235, § 2.

20-15-909. Implementation.

The State Board of Health shall promulgate regulations to provide for the distribution of human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) medications to Arkansas citizens without ample resources or available avenues to acquire their medically necessary medications.

History. Acts 2001, No. 235, § 3.

SUBCHAPTER 10 — BREAST CANCER — MAMMOGRAMS

SECTION.	SECTION.
20-15-1001. Legislative findings and intent.	20-15-1005. Fees.
20-15-1002. Definitions.	20-15-1006. Standards certification program.
20-15-1003. Advisory committee.	
20-15-1004. Accreditation of facilities required — Penalty.	

Effective Dates. Acts 1995, No. 508, § 9: Mar. 2, 1995. Emergency clause provided: “It is hereby found and determined by the General Assembly of the State of Arkansas that in order to comply with federal mandates and support the Arkansas Department of Health in its efforts to maintain high accreditation standards for mammography facilities, this act should have immediate effect. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate

preservation of the public peace, health, and safety, shall be in full force and effect from and after its passage and approval.”

20-15-1001. Legislative findings and intent.

The General Assembly finds and declares that:

(1) Breast cancer, according to the American Cancer Society, is the second leading cause of death among women in the United States;

(2) One (1) American woman in ten (10) will develop breast cancer in her lifetime;

(3) Mammography provides the earliest detection of breast cancer;

(4) Screening using mammography can significantly cut the death rate of women with breast cancer, especially for women with small tumors that have not invaded the lymph nodes and who have a ninety percent (90%) chance of surviving at least five (5) years when such tumors are diagnosed and removed;

(5) Both the American Cancer Society and the National Cancer Institute have developed age and frequency guidelines for mammogram screening, and those guidelines have been incorporated in this subchapter; and

(6) Therefore it is in the best interest for the general health and welfare of the people of the State of Arkansas that legislation be enacted encouraging health insurance coverage for screening mammography.

History. Acts 1989, No. 292, § 1.

20-15-1002. Definitions.

As used in this subchapter:

(1) “Accreditation body” means a body that has been approved by the United States Secretary of Health and Human Services to accredit mammography facilities under the federal Mammography Quality Standards Act of 1992, Pub. L. No. 102-539 (21 C.F.R. Part 900);

(2) “Diagnostic mammography” means a problem-solving radiologic procedure of higher intensity than screening mammography provided to a woman who is suspected of having breast pathology. A patient is usually referred for analysis of palpable abnormalities or for further evaluation of mammographically detected abnormalities. All images are immediately reviewed by the physician interpreting the study, and additional views are obtained as needed. A physical examination of the breast by the interpreting physician to correlate the radiologic findings is often performed as part of the study;

(3) “Mammography” means radiography of the breast; and

(4) “Screening mammography” means a radiologic procedure provided to a woman who has no signs or symptoms of breast cancer for the purpose of early detection of breast cancer. The procedure entails two (2) views of each breast and includes a physician’s interpretation of the results of the procedure.

History. Acts 1989, No. 292, § 2; 1995, No. 508, § 1; 2013, No. 1132, § 12.

Amendments. The 2013 amendment, in (1), inserted “the federal Mammography Quality Standards Act of 1992” and deleted “the federal Mammography Quality Standards Act of 1992” at the end; deleted former (3) and redesignated for-

mer (4) and (5) as present (3) and (4); and substituted “means” for “is” in (2) and present (4).

U.S. Code. The Mammography Quality Standards Act of 1992, referred to in this section, is codified as 42 U.S.C. § 263b.

20-15-1003. Advisory committee.

(a) To assure the safety and accuracy of screening and diagnostic mammography and to promote the highest quality imaging in the most efficient setting to contain costs, radiological standards, and quality assurance programs shall be established and administered by the Director of the Department of Health.

(b) To assist the Director of the Department of Health in establishing the quality standards, there is created an advisory committee to be composed of:

(1) The Director of Mammography at the University of Arkansas for Medical Sciences, or his or her designee;

(2) The Chair of the Breast Screening Project of the Arkansas Division of the American Cancer Society, or his or her designee;

(3) A physician appointed by the Arkansas Medical Society, Inc., or his or her designee;

(4) A health physicist from the Radiation Control Section of the Department of Health, or his or her designee;

(5) A medical physicist with experience and training in mammography procedures appointed by the Director of the Department of Health;

(6) A registered X-ray technologist with experience and training in mammography practices and procedures appointed by the Director of the Department of Health; and

(7) The President of the Arkansas Chapter of the American College of Radiology, or his or her designee.

(c) The committee and the Director of the Department of Health shall continuously review and revise the quality standards in light of current scientific knowledge, but no less frequently than one (1) time every year.

History. Acts 1989, No. 292, § 5; 1995, No. 508, § 3; 2013, No. 1132, § 13.

substituted “the” for “University Hospital” in (b)(1).

Amendments. The 2013 amendment

20-15-1004. Accreditation of facilities required — Penalty.

(a)(1) The Director of the Department of Health shall establish quality standards for accreditation of facilities wherein mammography may be conducted in accordance with the Mammography Quality Standards Act of 1992, Pub. L. No. 102-539 (21 C.F.R. Part 900).

(2) The standards applicable to the physician who interprets mammograms shall not be more stringent than those standards listed in the

Mammography Quality Standards Act of 1992, Pub. L. No. 102-539 (21 C.F.R. Part 900).

(b)(1) Such facilities shall be accredited by the Department of Health every three (3) years.

(2) No mammography shall be performed in an unaccredited facility after January 1, 1990.

(c) For facilities accredited by the department, documents of accreditation shall be nontransferable and shall expire three (3) years after being issued or at a time specified by the department.

(d) The owners of any unaccredited facility wherein mammography is performed after January 1, 1990, shall be subject to a civil penalty imposed by the department in an amount not to exceed one hundred dollars (\$100) for each day the facility operates without accreditation by the department.

History. Acts 1989, No. 292, § 6; 1995, No. 508, § 4. ity Standards Act of 1992, referred to in this section, is codified as 42 U.S.C. § 263b.

U.S. Code. The Mammography Qual-

20-15-1005. Fees.

(a) As an accreditation body, the Department of Health may charge and collect the following fees:

(1) First mammography tube, seven hundred dollars (\$700) to be collected at the beginning of each three-year accreditation period;

(2) Each additional mammography tube, five hundred dollars (\$500) to be collected at the beginning of each three-year accreditation period; and

(3) Each additional review of clinical images and phantoms, one hundred dollars (\$100) to be collected at the time of submission of clinical images and phantoms for review, except that the maximum annual cost for additional review of clinical images and phantoms shall not exceed three hundred dollars (\$300).

(b)(1) The department may prorate the accreditation fee for a mammography tube that is accredited for less than the three-year accreditation period.

(2) The department may bill on an annual basis for one-third ($\frac{1}{3}$) of the accreditation fee.

(c)(1) All revenue derived from fees collected pursuant to this section shall be deposited into the State Treasury and credited to the Public Health Fund.

(2) Subject to such rules and regulations as may be implemented by the Chief Fiscal Officer of the State, the disbursing officer for the department may transfer all unexpended funds that pertain to fees collected, as certified by the Chief Fiscal Officer of the State, to be carried forward and made available for expenditures for the same purpose in any following fiscal year.

History. Acts 1995, No. 508, § 5.

20-15-1006. Standards certification program.

The Department of Health may operate a mammography quality standards certification program in accordance with the Mammography Quality Standards Act of 1992, Pub. L. No. 102-539 (21 C.F.R. Part 900), to:

- (1) Issue initial and renewal certificates to mammography facilities;
- (2) Conduct inspections and determine compliance of certified facilities; and
- (3) Impose sanctions, to include:
 - (A) Suspension or revocation of certification;
 - (B) Injunctions to restrict unsafe or illegal activities in mammography facilities; and
 - (C) Civil penalties.

History. Acts 1995, No. 508, § 5.

U.S. Code. The federal Mammography

Standards Act of 1992, referred to in this section, is codified as 42 U.S.C. § 263b.

SUBCHAPTER 11 — NEWBORN INFANT HEARING SCREENING PROGRAM

SECTION.	SECTION.
20-15-1101. Purpose.	20-15-1105. Provision of services — Test results — Follow-up care.
20-15-1102. Definitions.	20-15-1106. Coordination of services.
20-15-1103. Creation.	20-15-1107. Immunity.
20-15-1104. Screening of newborns.	

Cross References. Universal Newborn Hearing Screening, Tracking, and Intervention Program and Advisory Board, § 20-15-1501 et seq.

Preambles. Acts 1993, No. 1096 contained a preamble which read:

“WHEREAS, uncorrected hearing loss during the critical language-learning period can severely limit a child’s capability for developing a complete and effective communication system; and

“WHEREAS, delayed identification also delays instruction in speech and language, auditory training and visual modes of communication, timely counseling, education for families and remedial intervention; and

“WHEREAS, the cost to provide special

education services increases significantly with delayed identification; and

“WHEREAS, while an estimated point seven percent (0.7%) or two hundred fifty (250) of the approximately thirty-six thousand (36,000) annual births in the state will suffer a permanent hearing impairment, only ten percent (10%) of those are currently being identified for early treatment; and

“WHEREAS, through early identification and follow-up, children born with hearing impairments can develop effective communication systems which improve their quality of life and increase their potential to become productive citizens;

“NOW THEREFORE,”

20-15-1101. Purpose.

The purpose of this subchapter is to provide a statewide coordinated early intervention program to identify and follow up with testing and treatment of newborn infants who are at risk for hearing impairment.

History. Acts 1993, No. 1096, § 1.

20-15-1102. Definitions.

As used in this subchapter:

(1) “Department” means the Department of Health;

(2) “Newborn infant with hearing impairment” means a newborn infant who has a disorder of the auditory system of any type or degree causing a hearing impairment sufficient to interfere with the development of language and speech skills;

(3) “Newborn infants at risk” means those newborn infants who are at risk for hearing impairment because they have one (1) or more risk factors;

(4) “Program” means the Newborn Infant Hearing Screening Program;

(5) “Risk factors” are those criteria or factors, any one (1) of which identifies a newborn infant as being at risk for hearing impairment, as determined by the department and set forth in rules and regulations promulgated by the department;

(6) “Screening infants for hearing impairment” means a procedure for employing a device for identifying a disorder of the auditory system, but the procedure may not necessarily provide a comprehensive determination of hearing thresholds in the speech range. Such a procedure may include auditory brainstem response screening or other devices approved by the department; and

(7) “Screening report” means a report by a facility providing screening for hearing impairment which identifies each newborn infant who has been screened for hearing impairment.

History. Acts 1993, No. 1096, § 2.

20-15-1103. Creation.

(a) There is established in the Department of Health a program to be known as the “Newborn Infant Hearing Screening Program”. The program shall provide for the early identification and follow-up of newborn infants at risk.

(b) The program shall include:

(1) Development through the promulgation of rules and regulations and criteria or factors to identify those newborn infants who are at risk for hearing impairment or of developing a progressive hearing impairment;

(2) Creation of a Hearing Impairment Registry to include, but not be limited to, the identification of newborn infants at risk for hearing impairment, infants with hearing impairment, and infants at risk of developing a progressive hearing impairment;

(3) Development of a hearing impairment at-risk questionnaire. The instrument shall be provided by the department to hospitals, birthing centers, and lay midwives for use in the program;

(4) Development of appropriate written materials regarding hearing impairment. The materials shall be provided to hospitals, birthing centers, and lay midwives for their use in the program;

(5) Development of a means of establishing contact with parents, guardians, and physicians of newborn infants with hearing impairment, of newborn infants at risk, and of infants at risk of developing a progressive hearing impairment;

(6) Establishment of a telephone hotline to communicate information about hearing impairment, hearing screening, audiological evaluation, and other services for infants with hearing impairment;

(7) Development of a screening report to be used by all facilities screening infants for hearing impairment to provide information to the department for a tracking system for newborn infants at risk; and

(8) A data collection system.

History. Acts 1993, No. 1096, § 3.

20-15-1104. Screening of newborns.

(a)(1) All hospitals, birthing centers, and lay midwives shall complete a hearing impairment at-risk questionnaire for each newborn infant before discharge or, in the case of a lay midwife, within seventy-two (72) hours of the birth of the infant.

(2) All hearing impairment at-risk questionnaires shall be completed by a designee of the hospital or birthing center or by the midwife.

(3) However, no infant shall be screened for hearing impairment whose parent presents a written statement that he or she objects to the screening of his or her child.

(b) The hospital, birthing center, or lay midwife shall forward to the Department of Health a copy of all completed questionnaires.

(c) The hospital, birthing center, or lay midwife shall provide the parents or guardians of all newborn infants with written materials provided by the department concerning hearing impairment.

History. Acts 1993, No. 1096, § 4;
1995, No. 1296, § 78.

20-15-1105. Provision of services — Test results — Follow-up care.

(a) The hospital, birthing center, or lay midwife may elect to provide for the screening of infants for hearing impairment but is not required to do so by this subchapter.

(b) Any facility screening infants for hearing impairment shall forward test results on a screening report to the Department of Health by the fifteenth of the month following the month in which the test was conducted.

(c) Any facility screening infants for hearing impairment shall provide information on locations at which medical and audiological fol-

low-up can be obtained by the parents or guardians of infants with hearing impairment.

History. Acts 1993, No. 1096, §§ 4, 5.

20-15-1106. Coordination of services.

The Department of Health, the Department of Education, and the Department of Human Services shall work cooperatively and develop a plan to coordinate early educational and rehabilitative services for newborn infants identified as hearing impaired.

History. Acts 1993, No. 1096, § 6.

20-15-1107. Immunity.

Any person or entity who reports in good faith and without malice or who in good faith and without malice fails to report the information required by this subchapter shall have immunity from any liability, civil or criminal, that might be incurred or imposed in any action resulting from such a report. Any such person or entity shall have the same immunity with respect to participation in any judicial proceeding resulting from such a report.

History. Acts 1993, No. 1096, § 7.

SUBCHAPTER 12 — IMMUNIZATION REGISTRATION

SECTION.

20-15-1201. Definitions.

20-15-1202. Statewide immunization registry.

SECTION.

20-15-1203. Duty of providers — Penalty.

20-15-1201. Definitions.

As used in this subchapter:

- (1) “Board” means the State Board of Health;
- (2) “Department” means the Department of Health; and
- (3) “Provider” means any healthcare professional who has direct or supervisory responsibility for the delivery of immunizations.

History. Acts 1995, No. 432, § 1.

20-15-1202. Statewide immunization registry.

(a)(1) The Department of Health shall establish a statewide immunization registry.

(2) Immunization records shall include data as specified by the department.

(b) The department may make information in the registry available to the parents or guardians of a child, to providers who report on the

immunization status of children in their care, and to such other persons or organizations designated by rule of the State Board of Health.

(c) The board shall adopt rules to implement this subchapter, including provisions for confidentiality of medical information.

(d) The department may enter into data-sharing agreements with federal, state, and local jurisdictions as well as the nations that are part of the Compact of Free Association islands to ensure effective surveillance and better immunization planning.

History. Acts 1995, No. 432, § 2; 1997, No. 869, § 1; 2011, No. 179, § 1; 2017, No. 880, § 1. deleted “regarding the immunization status of children” following “information” in (b); and added (d).

Amendments. The 2017 amendment

20-15-1203. Duty of providers — Penalty.

(a)(1) A provider shall register with the Department of Health the intent to administer childhood immunizations to an individual under twenty-two (22) years of age under guidelines established by the department.

(2) A provider shall report to the department the administration of a childhood immunization to an individual under twenty-two (22) years of age.

(3) A provider may report the administration of adult immunizations to individuals twenty-two (22) years of age or older to the department.

(b) A provider who administers a childhood immunization and fails to register with the department or make the required reports to the department, or both, shall be fined twenty-five dollars (\$25.00).

History. Acts 1995, No. 432, § 3; 2011, No. 179, § 2; 2013, No. 1132, § 14; 2015, No. 541, § 1. (a)(3)(B); and inserted “the administration of” in (a)(3)(B).

Amendments. The 2013 amendment inserted “to individuals twenty-two (22) years of age or older” in (a)(3)(A) and The 2015 amendment deleted former (a)(3)(B); and redesignated former (a)(3)(A) as (a)(3).

SUBCHAPTER 13 — BREAST CANCER ACT OF 1997

SECTION.	SECTION.
20-15-1301. Title.	20-15-1304. Advisory board — Breast Cancer Control Program.
20-15-1302. Legislative findings and intent.	
20-15-1303. Breast Cancer Research Program — Funding.	

Effective Dates. Acts 1997, No. 434, § 18: July 1, 1997. Emergency clause provided: “It is hereby found and determined that cancer is a leading cause of death among Arkansans; that, of cancer deaths, breast cancer claims more lives of women than any other type except lung cancer; that there are nineteen hundred (1900) new cases of breast cancer diagnosed each year; that breast cancer mortality rates have increased in Arkansas in recent years; that presently breast cancer is

claiming the lives of over four hundred seventy (470) women in Arkansas each year; that this number of deaths will increase as our population grows older; that information barriers result in women being unaware of the risk of breast cancer or the value of early detection; that financial barriers prevent some women from taking advantage of mammography; and that there is a lack of funding for breast cancer research in the state; it is further found and determined that to reduce the number of lives continuing to be needlessly lost, it is necessary to increase the state tax on cigarettes and tobacco products to provide funding for breast cancer, to provide for screening, diagnostic, and treatment services for women at risk of devel-

oping breast cancer and to assure continuing research with respect to the cause, cure and prevention of breast cancer. This act will provide greatly needed revenues to fund essential research and services with respect to the cause, cure, detection and prevention of breast cancer, and breast cancer education in the state. Therefore, an emergency is hereby declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall be in full force and effect from and after July 1, 1997."

Cross References. Tax on tobacco products to fund breast cancer control and research, see § 26-57-1103 et seq.

20-15-1301. Title.

This act shall be known and may be cited as the "Breast Cancer Act of 1997".

History. Acts 1997, No. 434, § 1.

434, codified as §§ 20-15-1301 — 20-15-

Meaning of "this act". Acts 1997, No.

1304 and 26-57-1101 — 26-57-1108.

20-15-1302. Legislative findings and intent.

The General Assembly finds and declares as follows:

(1) Breast cancer is a significant threat to the health of women. Breast cancer is the most common form of cancer in women and causes the death of a woman in the United States every twelve (12) minutes;

(2) The incidence of breast cancer continues to increase at a dramatic rate. During the past decade, the incidence has increased by thirty percent (30%). In 1960, one (1) woman in twenty (20) developed breast cancer over the course of her lifetime. By 1992, the probability had increased to one (1) woman in eight (8). At the current rate of increase, in the year 2000, one (1) woman in six (6) will develop breast cancer over the course of her lifetime. Presently, breast cancer claims the lives of over four hundred seventy (470) women in Arkansas each year;

(3) Breast cancer exacts an enormous economic toll on our society, including over two billion dollars (\$2,000,000,000) in direct medical costs, and over eight billion dollars (\$8,000,000,000) in both direct medical and indirect costs;

(4) Medical experts still do not know the cause of breast cancer or how to prevent breast cancer;

(5) The State of Arkansas must take the lead in combatting the increasingly rapid spread of breast cancer and the current lack of knowledge with respect to breast cancer's cause and cure and effective methods of prevention; and

(6) It is the intent of the General Assembly in enacting this act to fund essential research and services with respect to the cause, cure, detection and prevention of breast cancer, and breast cancer education.

History. Acts 1997, No. 434, § 2.

434, codified as §§ 20-15-1301 — 20-15-

Meaning of “this act”. Acts 1997, No. 1304 and 26-57-1101 — 26-57-1108.

20-15-1303. Breast Cancer Research Program — Funding.

There is established in the University of Arkansas a Breast Cancer Research Program. This program shall support research efforts into the cause, cure, treatment, earlier detection, and prevention of breast cancer and shall be administered according to the following principles:

(1) The program shall fund innovative research and the dissemination of successful research findings, with special emphasis on research that complements, rather than duplicates, the research funded by the United States Government and other entities;

(2)(A) All research grants shall be awarded on the basis of the research priorities established for the program and the scientific merit of the proposed research as determined by a peer review process governed by the Oversight Committee on Breast Cancer Research.

(B) The committee shall consist of seven (7) members appointed by the Governor, as follows:

(i) One (1) shall be appointed to represent the Arkansas Medical Society, Inc.;

(ii) One (1) shall represent the Arkansas Hospital Association, Inc.;

(iii) One (1) shall represent the medical oncology community;

(iv) One (1) shall be a women’s health advocate; and

(v) Three (3) shall represent the University of Arkansas system.

(C) Each of the four (4) congressional districts shall be represented by at least one (1) member.

(D) The members shall serve for a period of four (4) years;

(3) The peer review process for the selection of research grants awarded under this program shall be generally modeled on that used by the National Institutes of Health in its grant-making process, and the peer review process may stipulate that an applicant shall have participated in an established grant process before applying for a grant under this subchapter;

(4) An awardee shall be awarded grants for the full or partial cost of conducting the sponsored research grants and contracts; and

(5) All intellectual property assets developed under this program shall be treated in accordance with state and federal law.

History. Acts 1997, No. 434, § 3.

20-15-1304. Advisory board — Breast Cancer Control Program.

(a)(1) There is hereby established a Breast Cancer Control Advisory Board, which shall consist of eight (8) members appointed by the Governor, as follows:

(A) One (1) member shall be appointed to represent the Arkansas Medical Society, Inc.;

(B) One (1) member shall represent the Arkansas Chapter of Susan G. Komen;

(C) One (1) member shall represent the Arkansas Hospital Association, Inc.;

(D) One (1) member shall represent the American Cancer Society;

(E) One (1) member shall represent the Arkansas Nurses Association;

(F) One (1) member shall represent the medical oncology community;

(G) One (1) member shall represent the radiation oncology community; and

(H) One (1) member shall be a women's health advocate.

(2) Each of the four (4) congressional districts shall be represented by at least one (1) member.

(3) The members shall serve for a period of four (4) years.

(b)(1) There is established in the Department of Health the Breast Cancer Control Program. This program shall provide for the early detection, diagnosis, and treatment of breast cancer.

(2) The program shall be administered according to the following principles:

(A) The program shall provide for breast cancer education and awareness so as to ensure early detection and conduct surveillance activities across the state;

(B) The program shall provide screening of women for breast cancer, including mammography, as an early detection healthcare measure;

(C) After screening, the program shall provide medical referrals and financial assistance for services necessary for definitive diagnoses, including nonradiological techniques and biopsy; and

(D) If a positive diagnosis is made, the program shall provide the necessary advocacy and financial assistance to help the person obtain necessary treatment.

History. Acts 1997, No. 434, § 4.

SUBCHAPTER 14 — OSTEOPOROSIS PREVENTION EDUCATION ACT OF 1997**SECTION.**

20-15-1401. Title.

20-15-1402. Legislative findings.

20-15-1403. Osteoporosis prevention and treatment education program — Funding.

SECTION.

20-15-1404. Evaluation by the Department of Health.

20-15-1401. Title.

This subchapter may be cited as the “Osteoporosis Prevention Education Act of 1997”.

History. Acts 1997, No. 732, § 1.

20-15-1402. Legislative findings.

It is found and determined by the General Assembly that:

(1) Osteoporosis, a bone-thinning disease, is a major public health problem that poses a threat to the health and quality of life of as many as twenty-five million (25,000,000) Americans;

(2) The annual direct and indirect costs of osteoporosis to the healthcare system are estimated to be as high as eighteen billion dollars (\$18,000,000,000) in 1993 and are expected to rise above sixty billion dollars (\$60,000,000,000) in the year 2020;

(3) Since osteoporosis progresses silently and currently has no cure, prevention, early diagnosis, and treatment are keys to reducing the prevalence of devastation from this disease;

(4) Experts in the field of osteoporosis believe that with greater awareness of the value of prevention among medical experts, service providers, and the public, osteoporosis will be preventable and treatable in the future, thereby reducing the costs of long-term care and improving the quality of life for all Americans; and

(5) Educating the public and the healthcare community throughout the State of Arkansas about this potentially devastating disease is of paramount importance and is in every respect in the public interest and to the benefit of all Arkansans.

History. Acts 1997, No. 732, § 2.

20-15-1403. Osteoporosis prevention and treatment education program — Funding.

(a) The Department of Health shall coordinate with other agencies and organizations as funds become available to establish, promote, and maintain an osteoporosis prevention and treatment education program in order to raise public awareness, to educate consumers, to educate and train health professionals and service providers, and to carry out other purposes.

(b) For purposes of administering this subchapter, the State Health Officer shall do all of the following:

(1) Identify the appropriate entities to carry out an osteoporosis prevention and treatment education program;

(2) Work to improve the capacity of community-based services to osteoporosis patients;

(3) Work with governmental offices, community and business leaders, community organizations, healthcare and human service providers, and national osteoporosis organizations to coordinate efforts and

maximize state resources in the areas of prevention, education, and treatment of osteoporosis; and

(4) Identify and, as funds become available, replicate or use successful osteoporosis programs and procure related materials and services from organizations with appropriate expertise and knowledge of osteoporosis.

(c) As funds become available, the department shall use the following strategies for raising public awareness on the causes and nature of osteoporosis, the personal risk factors, the value of prevention and early detection, and the options for diagnosing and treating the disease:

(1) An outreach campaign utilizing print, radio, and television public service announcements, advertisements, posters, and other materials;

(2) Providing health information and risk factor assessment in regard to osteoporosis at public events;

(3) Targeting populations at risk for osteoporosis;

(4) Providing reliable information about osteoporosis to policy makers;

(5) Distributing information through county health departments, schools, area agencies on aging, employer wellness programs, physicians, hospitals and health maintenance organizations, women's groups, nonprofit organizations, and community-based organizations; and

(6) Any other strategy for raising public awareness about osteoporosis that is consistent with the provisions of this subchapter.

(d) As funds become available, the department shall use the following strategies for educating and training physicians, health professionals, and community service providers in regard to the most up-to-date, accurate scientific and medical information on osteoporosis prevention, diagnosis, and treatment, therapeutic decision-making about osteoporosis, guidelines for detecting and treating osteoporosis in special populations, and risks and benefits of medications and research advances:

(1) Identify and obtain educational materials for the professional healthcare provider which translate the latest scientific and medical information into clinical applications;

(2) Raise awareness among professional healthcare providers as to the importance of osteoporosis prevention, early detection, treatment, and rehabilitation; and

(3) Provide workshops and seminars for in-depth professional development in the field of the care and management of the patient with osteoporosis.

History. Acts 1997, No. 732, § 3.

20-15-1404. Evaluation by the Department of Health.

The Department of Health may evaluate any or all of the following:

(1) The research on osteoporosis being conducted within the state;

- (2) The available technical assistance, educational materials, and osteoporosis programs nationwide;
- (3) The level of public and professional awareness about osteoporosis;
- (4) The needs of osteoporosis patients, their families, and their caregivers;
- (5) The needs of healthcare providers, including physicians, nurses, and managed care organizations, in regard to caring for the osteoporosis patient;
- (6) The services available to the osteoporosis patient;
- (7) The existence of osteoporosis treatment programs;
- (8) The existence of osteoporosis support groups; and
- (9) The existence of rehabilitation services for osteoporosis patients.

History. Acts 1997, No. 732, § 4.

SUBCHAPTER 15 — UNIVERSAL NEWBORN HEARING SCREENING, TRACKING, AND INTERVENTION PROGRAM AND ADVISORY BOARD

SECTION.	SECTION.	
20-15-1501. Purpose.		Intervention
20-15-1502. Definitions.		Board.
20-15-1503. Universal Newborn Hearing Screening, Tracking, and	20-15-1504. Testing — Results.	Advisory
	20-15-1505. Exemption.	

20-15-1501. Purpose.

The purpose of this subchapter is to:

- (1) Provide early detection of hearing loss by physiological measurement in newborn children at the birthing facility or as soon after birth as possible;
- (2) Enable these children and their families and caregivers to obtain needed multidisciplinary evaluation, treatment, and intervention services at the earliest opportunity;
- (3) Prevent or mitigate the developmental delays and academic failures associated with late identification of hearing loss; and
- (4) Provide the state with the information necessary to effectively plan, establish, and evaluate a comprehensive system of appropriate services for newborns and infants who have a hearing loss or are deaf.

History. Acts 1999, No. 1559, § 1.

20-15-1502. Definitions.

As used in this subchapter:

- (1) “Birth admission” means the time after birth that the newborn remains in the hospital nursery before discharge;
- (2) “Birthing hospital” means any hospital located within the State of Arkansas that delivers newborns;
- (3) “Board” means the Universal Newborn Hearing Screening, Tracking, and Intervention Advisory Board;

- (4) "Director" means the Director of the Department of Health;
- (5) "Department" means the Department of Health;
- (6) "Follow-up care" and "follow-up screening" means the follow-up services provided by a licensed audiologist to diagnose a hearing loss;
- (7) "Hearing loss" means an impairment that is a dysfunction of the auditory system of any type or degree sufficient to interfere with acquisition and development of speech and language skills;
- (8) "Hearing screening" means a bilateral physiological measurement of hearing on a newborn or infant;
- (9) "Infant" means a child thirty (30) days to twelve (12) months old;
- (10) "Intervention" means amplification by a licensed audiologist as required and early intervention services described in Part H of the Individuals with Disabilities Education Act as in effect January 1, 1999;
- (11) "Newborn" means a child up to twenty-nine (29) days old;
- (12) "Parent" means a natural parent, stepparent, adoptive parent, legal guardian, or other legal custodian of a child;
- (13) "Program" means the Universal Newborn Infant Hearing Screening, Tracking, and Intervention Program; and
- (14) "Provider" means an audiologist licensed by the State of Arkansas who administers initial newborn and infant hearing screenings upon referral from a hospital or physician or follow-up screenings outside of the hospital setting.

History. Acts 1999, No. 1559, § 2.

§ 1400 et seq. Former Part H, concerning infants and toddlers with disabilities, is now repealed. For current provisions, see 20 U.S.C. § 1431 et seq.

U.S. Code. The Individuals with Disabilities Education Act, referred to in this section, is primarily codified as 20 U.S.C.

20-15-1503. Universal Newborn Hearing Screening, Tracking, and Intervention Advisory Board.

(a) There is created the Universal Newborn Hearing Screening, Tracking, and Intervention Advisory Board.

(b)(1) The board shall be composed of seven (7) members appointed by the Governor, after consulting the Arkansas Speech-Language-Hearing Association, Inc., from the following professions or groups:

- (A) One (1) audiologist;
- (B) One (1) audiologist from the Department of Health;
- (C) One (1) audiologist from Arkansas Children's Hospital;
- (D) One (1) speech-language pathologist;
- (E) One (1) pediatrician-neonatologist or ear, nose, and throat physician;
- (F) One (1) adult who is deaf or hard of hearing to represent consumer organizations for deaf and hard of hearing persons; and
- (G) One (1) consumer of services who is a parent of a child or children with hearing loss.

(2) Appointments made by the Governor under this subsection shall be subject to confirmation by the Senate.

(c)(1) Members shall be appointed for three-year staggered terms to be assigned by lot.

(2) The terms shall commence on January 15 of each year.

(d) The board shall annually select by a majority vote one (1) of its members to serve as a chair and one (1) to serve as vice chair.

(e) The Governor may remove any member of the board for misconduct, incompetency, or neglect of duty, or for any malfeasance in office.

(f) The board shall act by majority vote and as required by the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(g) The board shall have the authority to recommend rules and regulations to implement this subchapter, and the department shall promulgate these rules and regulations by July 1, 2000.

(h)(1) The board shall hold its first meeting within thirty (30) days of July 30, 1999, at a place designated by the department.

(2) Subsequent meetings shall be held quarterly at the call of the Chair of the Universal Newborn Hearing Screening, Tracking, and Intervention Advisory Board or as often as necessary to make recommendations to the department so that the rules and regulations implementing this subchapter can be promulgated by July 1, 2000.

(3) The board shall complete an annual report for the House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor which provides information such as, but not limited to, the number of hospitals in compliance with this subchapter, the number of hearing-impaired infants identified, and the availability of follow-up services.

(i) The department shall provide administrative support services required by the board.

(j) Members shall not be entitled to compensation for their services but may receive expense reimbursement and a stipend in accordance with § 25-16-901 et seq.

History. Acts 1999, No. 1559, § 3; 2015, No. 1100, § 49.

Amendments. The 2015 amendment redesignated former (b) as present (b)(1); substituted “after consulting” for “with

recommendations from” in the introductory language of present (b)(1); changed designations in (b)(1) from numbers to letters; and added (b)(2).

20-15-1504. Testing — Results.

(a) After July 30, 1999, and promulgation of rules and regulations, every birthing hospital in this state with more than fifty (50) births per year shall provide or arrange for a bilateral physiological hearing screening on each birth admission. Medicaid shall reimburse the birthing hospital for the physiological screening with the reimbursement equal to that amount paid outpatient providers for the same service in addition to the current rate of per diem paid to the hospital.

(b) Any birthing hospital, provider, or physician administering initial hearing screenings to newborns and infants shall forward test results on a screening report to the Department of Health by the fifteenth day of the month following the month in which the test was conducted.

(c) Any birthing hospital, provider, or physician screening newborns and infants shall provide information on locations at which medical and audiological follow-up care and follow-up screening can be obtained by the parents or guardians of the newborns and infants.

(d) All providers or physicians completing follow-up screening or follow-up care for the hearing impairment shall forward test results on a screening report to the department by the fifteenth day of the month following the month in which the test was conducted.

History. Acts 1999, No. 1559, § 4.

20-15-1505. Exemption.

No test is to be performed if the parent of a newborn or infant dissents on the ground that the test conflicts with a personal religious belief or practice.

History. Acts 1999, No. 1559, § 5.

SUBCHAPTER 16 — PROSTATE CANCER ACT OF 1999

SECTION.

20-15-1601 — 20-15-1604. [Repealed.]

20-15-1601 — 20-15-1604. [Repealed.]

Publisher's Notes. This subchapter, concerning the Prostrate Cancer Act of 1999, was repealed by Acts 2009, No. 1484, § 6. The subchapter was derived from the following sources:

20-15-1601. Acts 1999, No. 397, § 1.	20-15-1602. Acts 1999, No. 397, § 2; 2001, No. 1455, § 1.
	20-15-1603. Acts 1999, No. 397, § 3; 2001, No. 1455, § 2; 2003, No. 865, § 2.
	20-15-1604. Acts 1999, No. 397, § 4; 2001, No. 1455, § 3; 2003, No. 865, § 3.

SUBCHAPTER 17 — COLORECTAL CANCER ACT OF 2005

SECTION.

20-15-1701 — 20-15-1703. [Repealed.]

20-15-1701 — 20-15-1703. [Repealed.]

Publisher's Notes. This subchapter, concerning the Colorectal Cancer Act of 2005, was repealed by Acts 2009, No. 1374. The subchapter was derived from the following sources:

20-15-1701. Acts 2005, No. 2236, § 1.
20-15-1702. Acts 2005, No. 2236, § 1.
20-15-1703. Acts 2005, No. 2236, § 1.

SUBCHAPTER 18 — ARKANSAS HIV-AIDS MINORITY TASK FORCE ACT OF 2007

SECTION.

20-15-1801 — 20-15-1805. [Repealed.]

20-15-1801 — 20-15-1805. [Repealed.]

Publisher’s Notes. This subchapter, concerning the Arkansas HIV-AIDS Minority Task Force Act of 2007, was repealed by Acts 2017, No. 540, § 46. The subchapter was derived from the following sources:

20-15-1801. Acts 2007, No. 842, § 1.

20-15-1802. Acts 2007, No. 842, § 1.

20-15-1803. Acts 2007, No. 842, § 1; 2009, No. 1484, § 7; 2011, No. 1230, § 1; 2013, No. 1132, § 15.

20-15-1804. Acts 2007, No. 842, § 1.

20-15-1805. Acts 2007, No. 842, § 1.

SUBCHAPTER 19 — COLORECTAL CANCER PREVENTION, EARLY DETECTION, AND TREATMENT ACT

SECTION.	SECTION.
20-15-1901. Title.	Treatment Advisory Committee.
20-15-1902. Findings.	
20-15-1903. Definition.	20-15-1907. Colorectal Cancer Research Program.
20-15-1904. Program for prevention of colorectal cancer.	20-15-1908. Oversight Committee on Colorectal Cancer Research.
20-15-1905. Program requirements.	
20-15-1906. Colorectal Cancer Prevention, Early Detection, and	

20-15-1901. Title.

This subchapter shall be known and may be cited as the “Colorectal Cancer Prevention, Early Detection, and Treatment Act”.

History. Acts 2009, No. 1374, § 1; 2017, No. 516, § 1.

Amendments. The 2017 amendment deleted “of 2009” following “Act”.

20-15-1902. Findings.

- (a) The General Assembly finds that:
- (1)(A) Colorectal cancer is the second leading cause of cancer death in Arkansas.
- (B) An estimated one thousand six hundred thirty (1,630) new cases of colorectal cancer were diagnosed in Arkansas during 2009.
- (C) An estimated one thousand four hundred (1,400) new cases of colorectal cancer will be diagnosed in Arkansas during 2017.
- (D) An estimated six hundred (600) Arkansans will have colorectal cancer listed as the cause of death in 2017.
- (E) Arkansas presently has higher incidences of colorectal cancer and higher rates of death resulting from colorectal cancer than the national average.
- (F) A 2015 cancer surveillance study published in the journal of Cancer, Epidemiology, Biomarkers, and Prevention by R.L. Siegel et al. indicates that the higher rates of colorectal cancer are experienced in the following seventeen (17) counties:
- (i) Randolph;
 - (ii) Clay;
 - (iii) Mississippi;
 - (iv) Poinsett;

- (v) Woodruff;
- (vi) Cross;
- (vii) Crittenden;
- (viii) Lee;
- (ix) Monroe;
- (x) Arkansas;
- (xi) Phillips;
- (xii) Desha;
- (xiii) Chicot;
- (xiv) Drew;
- (xv) Jefferson;
- (xvi) Dallas; and
- (xvii) Jackson;

(2)(A) Screening for colorectal cancer may identify the precursors of cancer before the disease begins and the precursors may be removed, thus preventing the emergence of most colorectal cancer.

(B) Currently, only fifty-nine percent (59%) of Arkansans who are at risk for colorectal cancer or who are above fifty (50) years of age have been screened.

(C) On April 19, 2016, Governor Asa Hutchinson signed the “80% by 2018” pledge dedicating his commitment to increase colorectal cancer screenings to eighty percent (80%) by 2018.

(D) Arkansas presently ranks forty-sixth in the nation for colorectal screenings among individuals who are fifty (50) years of age or older; and

(3) The Colorectal Cancer Control Demonstration Project created in the Colorectal Cancer Act of 2005, Acts 2005, No. 2236 [repealed], has produced findings indicating that:

(A)(i) Statewide only fifty percent (50%) of adults over fifty (50) years of age have received colorectal cancer screening within the recommended time interval and thirty-five percent (35%) have never been screened.

(ii) Screening rates are twenty-five percent (25%) lower in underserved areas of the state where healthcare services, health insurance coverage, educational attainment, and household income are limited;

(B)(i) Forty percent (40%) of Arkansans who should be screened for colorectal cancer have never received physician advice to be screened.

(ii) An individual in an underserved area of the state is less likely to receive appropriate advice about effective screening methods than is an individual in a better-served area of the state;

(C)(i) Fewer than forty percent (40%) of Arkansas citizens know that periodic screening for colorectal cancer should start at fifty (50) years of age.

(ii) Fifty-six percent (56%) of Arkansas citizens rate themselves as being at low risk for colorectal cancer.

(iii) Forty-two percent (42%) of Arkansas citizens identify cost as a significant barrier to screening; and

(D)(i) Eighty-one percent (81%) of low-income patients enrolled in the demonstration project successfully completed colorectal screening.

(ii) A statewide screening program for underserved individuals could reduce cancer incidence among screened individuals by thirty-two percent (32%), reduce five-year mortality risk by twenty-five percent (25%), and reduce cancer treatment costs by fifty-four percent (54%).

(b) This subchapter is intended to reduce the physical and economic burden of colorectal cancer in Arkansas.

History. Acts 2009, No. 1374, § 1; 2011, No. 1121, § 3; 2017, No. 516, § 1

Amendments. The 2017 amendment substituted “were” for “will be” in (a)(1)(B); added (a)(1)(C) through (a)(1)(F); redesignated former (a)(2) as (a)(2)(A); added (a)(2)(B) through (a)(2)(D); substituted “Acts 2005, No. 2236

[repealed]” for “§ 20-15-1701 et seq.” in the introductory language of (a)(3); substituted “fifty percent (50%)” for “one-half (½)” in (a)(3)(A)(i); deleted “by supporting research and cancer control activities across Arkansas” following “in Arkansas” in (b); and made stylistic changes.

20-15-1903. Definition.

As used in this subchapter, “high risk” means:

(1) An individual over fifty (50) years of age or who faces a high risk for colorectal cancer because of:

(A) The presence of one (1) or more polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy;

(B) Family history of colorectal cancer;

(C) Genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis;

(D) Personal history of colorectal cancer, ulcerative colitis, or Crohn’s disease; or

(E) The presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and

(2) Any additional or expanded definition of “persons at high risk for colorectal cancer” as recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

History. Acts 2009, No. 1374, § 1; 2017, No. 516, § 1

Amendments. The 2017 amendment inserted “one (1) or more” in (1)(A).

20-15-1904. Program for prevention of colorectal cancer.

(a) There is created in the Department of Health the Arkansas Colorectal Cancer Prevention, Early Detection, and Treatment Program if funds are available.

(b) The Winthrop P. Rockefeller Cancer Institute at the University of Arkansas for Medical Sciences may collaborate with the department in conducting the program.

(c)(1) The program shall be designed in conformity with federal law and regulations regarding a program for prevention, early detection, and treatment of colorectal cancer.

(2) Funds shall not be used to supplant funds already available for prevention, early detection, and treatment of colorectal cancer.

(d) A contract may be made under this subchapter only if:

(1) In providing screenings for colorectal cancer, priority is given to individuals who lack adequate coverage under health insurance and health plans for screenings for colorectal cancer;

(2) Screenings are carried out as preventive health measures in accordance with evidence-based screening guidelines and procedures;

(3) A payment made through the program for a screening procedure will not exceed the amount specified under federal law and regulations regarding a grant program for prevention, early detection, and treatment of colorectal cancer;

(4) Funds shall not be spent to make payment for any item or service if that payment has been made or can reasonably be expected to be made:

(A) Under a state compensation program, an insurance policy, or a federal or state health benefits program; or

(B) By an entity that provides health services on a prepaid basis; and

(5) Fiscal controls and fund accounting procedures are established to ensure proper disbursement of and accounting for amounts received under this subchapter.

(e) Upon request, the department shall provide records maintained under this subchapter to the appropriate federal oversight agency.

(f) The program shall be implemented statewide.

History. Acts 2009, No. 1374, § 1; 2017, No. 516, § 1 deleted “low-income” preceding “individuals” in (d)(1); and substituted “shall” for

Amendments. The 2017 amendment “will” in (d)(4).

20-15-1905. Program requirements.

The Arkansas Colorectal Cancer Prevention, Early Detection, and Treatment Program funded under this subchapter shall:

(1) Provide screenings and diagnostic tests for colorectal cancer to individuals who are:

(A) Fifty (50) years of age or older; or

(B) Under fifty (50) years of age and at high risk for colorectal cancer;

(2) Provide appropriate case management and referrals for medical treatment of individuals screened under the program created in this subchapter;

(3) Directly or through coordination or an arrangement with health-care providers or programs ensure the full continuum of follow-up and cancer care for individuals screened in the program, including without limitation:

- (A) Appropriate follow-up for abnormal tests;
- (B) Diagnostic services;
- (C) Therapeutic services; and
- (D) Treatment of detected cancers and management of unanticipated medical complications;
- (4) Carry out activities to improve the education, training, and skills of health professionals, including allied health professionals in the detection and control of colorectal cancer;
- (5) Establish mechanisms to monitor the quality of screening and diagnostic follow-up procedures for colorectal cancer;
- (6) Create and implement appropriate monitoring systems to monitor, including without limitation:
 - (A) The number of facilities in the state that provide screening services in accordance with evidence-based screening guidelines and procedures;
 - (B) Physicians, including family practitioners, gastroenterologists, and surgical endoscopists who perform colonoscopies in the state and the regions of the state in which the physicians practice;
 - (C) Differences in cost across facilities as compared to Medicare payment for procedures; and
 - (D) Available resources for follow-up diagnostics and treatment as needed;
- (7) Develop and disseminate findings derived from the monitoring systems;
- (8) Develop and disseminate public information and education programs for the detection and control of colorectal cancer and for promoting the benefits of receiving screenings for the public and for healthcare professions, to include without limitation education concerning:
 - (A) High-risk populations;
 - (B) Target populations; and
 - (C) The uninsured and underinsured;
- (9) Develop provider-oriented programs to promote routine implementation of screening guidelines and patient-oriented programs to increase utilization of screening and diagnostic services; and
- (10) Make records of program activities and expenditures available to the Department of Health.

History. Acts 2009, No. 1374, § 1; Cancer Prevention, Early Detection, and Treatment Program” for “A program” in 2011, No. 1121, § 4; 2017, No. 516, § 1

Amendments. The 2017 amendment substituted “The Arkansas Colorectal” in the introductory language; rewrote (1)(B); deleted (1)(C); and made stylistic changes.

20-15-1906. Colorectal Cancer Prevention, Early Detection, and Treatment Advisory Committee.

(a) There is created a Colorectal Cancer Prevention, Early Detection, and Treatment Advisory Committee to advise the Director of the Department of Health on matters of concern under this subchapter.

(b) The director shall appoint:

(1) One (1) member to represent the Department of Health;

(2) One (1) member to represent the target population of this subchapter;

(3) One (1) member who specializes in primary care or gastrointestinal medicine to represent the Arkansas Medical Society, Inc.;

(4) One (1) member who specializes in primary care or gastrointestinal medicine to represent the Arkansas Medical, Dental and Pharmaceutical Association, Inc.;

(5) One (1) member who is a surgical oncologist physician;

(6) One (1) member who is a radiation oncologist physician;

(7) One (1) member to represent the Arkansas Nurses Association;

(8) One (1) member who is a behavioral health scientist;

(9) One (1) member who is a medical oncologist physician;

(10) One (1) member to represent the area health education centers;

(11) One (1) member who is a colorectal cancer survivor;

(12) One (1) member to represent the American Cancer Society;

(13) One (1) member to represent the Community Health Centers of Arkansas, Inc.; and

(14) One (1) member selected from the Arkansas Minority Health Commission.

(c) The director shall ensure that the membership is representative of the four (4) congressional districts.

(d) Terms of committee members shall be three (3) years except for the initial members whose terms shall be determined by lot so as to stagger terms to equalize as nearly as possible the number of members to be appointed each year.

(e) If a vacancy occurs, the director shall appoint a person who represents the same constituency as the member being replaced.

(f) The committee shall elect one (1) of its members to act as chair for a term of one (1) year.

(g) A majority of the members shall constitute a quorum for the transaction of business.

(h) The committee shall meet at least quarterly to study developments in programs created under this subchapter and to assist the director in improving existing programs and developing new programs.

(i) The department shall provide office space and staff for the committee.

(j) Members of the committee shall serve without pay but may receive expense reimbursement in accordance with § 25-16-902 if funds are available.

History. Acts 2009, No. 1374, § 1; 2017, No. 516, § 1

Amendments. The 2017 amendment inserted “represent” in (b)(2); substituted

“Arkansas Nurses Association” for “Arkansas Nursing Association” in (b)(7); and added (b)(14).

20-15-1907. Colorectal Cancer Research Program.

(a) There is established within the Winthrop P. Rockefeller Cancer Institute at the University of Arkansas for Medical Sciences, in collaboration with the Department of Health, the Colorectal Cancer Research Program.

(b) The program may conduct without limitation:

(1) Research into the cause, cure, treatment, early detection, and prevention of colorectal cancer and the survivorship of individuals diagnosed with colorectal cancer;

(2) Examinations of behavioral and educational strategies to promote screening and early detection; and

(3) Research addressing health policies and legislative initiatives intended to promote early detection and reduce the burden of colorectal cancer.

(c) The program shall fund innovative research and the dissemination of successful research findings with special emphasis on research that complements, rather than duplicates, the research funded by the United States Government and other entities.

History. Acts 2009, No. 1374, § 1; substituted “the Colorectal” for “a Colorectal” in (a).
2017, No. 516, § 1

Amendments. The 2017 amendment

20-15-1908. Oversight Committee on Colorectal Cancer Research.

(a) There is created the Oversight Committee on Colorectal Cancer Research.

(b) All research grants shall be awarded on the basis of the research priorities established for the Colorectal Cancer Research Program and the scientific merit of the proposed research as determined by a peer review process governed by the committee.

(c) The committee shall consist of seven (7) members appointed by the Director of the Winthrop P. Rockefeller Cancer Institute at the University of Arkansas for Medical Sciences, as follows:

(1) One (1) member to represent the Arkansas Medical Society, Inc.;

(2) One (1) member to represent the Arkansas Hospital Association, Inc.;

(3) One (1) member to represent the medical, surgical, or radiation oncology community;

(4) One (1) member who is a colorectal health advocate;

(5) One (1) member to represent the University of Arkansas who has experience in biomedical research relevant to cancer prevention and control;

(6) One (1) member to represent the University of Arkansas who has experience in behavioral and psychosocial research relevant to cancer prevention and control; and

(7) One (1) member to represent the University of Arkansas who has experience in systems research relevant to cancer prevention and control.

(d) Each of the four (4) congressional districts shall be represented by at least one (1) member.

(e)(1) The members shall serve for a period of four (4) years.

(2) The members shall serve staggered terms to be determined by lot at the first meeting of the committee so that one (1) member serves one (1) year, two (2) members serve two (2) years, two (2) members serve three (3) years, and two (2) members serve four (4) years.

History. Acts 2009, No. 1374, § 1; 2017, No. 516, § 1

Amendments. The 2017 amendment deleted “System” following “University of Arkansas” in (c)(5), (c)(6), and (c)(7); substituted “behavioral and psychosocial” for “behavioral/psychosocial” in (c)(6); and, in (e)(2), inserted “member” once and “members” following “(2)” three times.

SUBCHAPTER 20 — DIABETES ACTION PLAN

SECTION.

20-15-2001. Agency collaboration.

20-15-2002. Reporting.

SECTION.

20-15-2003. Applicability.

20-15-2001. Agency collaboration.

The Department of Human Services and the Department of Health shall collaborate to identify goals and benchmarks while also developing individual entity plans to reduce the incidence of diabetes in Arkansas, improve diabetes care, and control complications associated with diabetes.

History. Acts 2015, No. 167, § 1.

20-15-2002. Reporting.

The Department of Human Services and the Department of Health shall submit a report to the Legislative Council by January 10 of each even-numbered year, including without limitation the following:

(1) The financial impact and reach that diabetes of all types are having on each agency, localities, and the state, including without limitation:

(A) The number of individuals with diabetes that are impacted or covered by the agency;

(B) The number of individuals with diabetes and family members who are impacted by prevention and diabetes control programs implemented by the agency;

(C) The financial toll or impact diabetes and its complications places on the program; and

(D) The financial toll or impact diabetes and its complications places on the program in comparison to other chronic diseases and conditions;

- (2) An assessment of the benefits of implemented programs and activities that:
- (A) Aims at controlling diabetes and preventing the disease; and
 - (B) Documents the amount and source for funding directed to the agency or entity from the General Assembly for programs and activities aimed at reaching individuals with diabetes;
- (3) A description of the level of coordination existing among the agencies and other entities of activities, programs, and messages on managing, treating, or preventing all forms of diabetes and its complications;
- (4)(A) The development or revision of detailed action plans for battling diabetes with a range of actionable items for consideration by the General Assembly.
- (B) The plans shall identify:
- (i) Proposed actions to reduce the impact of diabetes, prediabetes, and related complications caused by diabetes;
 - (ii) Expected outcomes of the actions proposed; and
 - (iii) Benchmarks for controlling and preventing relevant forms of diabetes; and
- (5) The development of a detailed budget blueprint:
- (A) Identifying needs, costs, and resources required to implement the plan identified in subdivision (4) of this section; and
 - (B) Including a budget range for all options presented in the plan identified in subdivision (4) of this section for consideration by the General Assembly.

History. Acts 2015, No. 167, § 1.

20-15-2003. Applicability.

The requirements of this subchapter are limited to the diabetes information, data, initiatives, and programs within each agency before July 22, 2015, unless there is available funding for diabetes in each agency that may be used for new research, data collection, reporting, or other requirements of this subchapter.

History. Acts 2015, No. 167, § 1.

SUBCHAPTER 21 — RIGHT TO TRY ACT

SECTION.	SECTION.
20-15-2101. Title.	20-15-2107. Insurance coverage.
20-15-2102. Findings.	20-15-2108. Prohibited sanctions.
20-15-2103. Definitions.	20-15-2109. Remedy.
20-15-2104. Eligibility.	20-15-2110. Immunity.
20-15-2105. Availability.	20-15-2111. Medicaid coverage.
20-15-2106. Costs — Definition.	

20-15-2101. Title.

This subchapter shall be known and may be cited as the “Right to Try Act”.

History. Acts 2015, No. 374, § 1.

20-15-2102. Findings.

It is found and determined by the General Assembly of the State of Arkansas that:

(1) The process of approval for investigational drugs, biological products, and devices in the United States often takes many years;

(2) Patients who have a terminal disease do not have the luxury of waiting until an investigational drug, biological product, or device receives final approval;

(3) The standards of the United States Food and Drug Administration for the use of investigational drugs, biological products, and devices may deny the benefits of potentially life-saving treatments to terminally ill patients;

(4) The State of Arkansas recognizes that patients who have a terminal disease have a fundamental right to attempt to pursue the preservation of their own lives by accessing available investigational drugs, biological products, and devices; and

(5) The use of available investigational drugs, biological products, or devices is a decision that should be made by the patient with a terminal disease in consultation with his or her physician.

History. Acts 2015, No. 374, § 1.

20-15-2103. Definitions.

As used in this subchapter:

(1) “Eligible patient” means a person who meets the requirements of eligibility in § 20-15-2104;

(2) “Investigational drug, biological product, or device” means a drug, biological product, or device that:

(A) Has successfully completed phase I of clinical trials but has not been approved for general use by the United States Food and Drug Administration; and

(B) Remains currently under investigation in a United States Food and Drug Administration clinical trial;

(3) “Physician” means an individual licensed to practice medicine in the State of Arkansas under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.; and

(4) “Terminal illness” means an incurable and irreversible condition that without the administration of life-sustaining treatment will, in the opinion of the patient’s physician, result in death within a relatively short time.

History. Acts 2015, No. 374, § 1.

20-15-2104. Eligibility.

In order for a patient to access an investigational drug, biological product, or device under this subchapter, a physician must document in the patient's medical record and chart that the patient:

- (1) Has a terminal illness;
- (2) Has a determination from a qualified physician that the patient has no comparable or satisfactory treatment options approved by the United States Food and Drug Administration available to treat the terminal illness and that the probable risk to the patient from the investigational drug, biological product, or device is not greater than the probable risk from the terminal illness;
- (3) Has been unable to participate in a clinical trial for the terminal illness within one hundred (100) miles of the patient's home address or has not been accepted to the clinical trial within one (1) week of the completion of the clinical trial application process;
- (4) Has been given a prescription by a physician for an investigational drug, biological product, or device;
- (5)(A) Has given informed consent in writing for the use of the investigational drug, biological product, or device.
(B) If the patient is a minor or lacks the mental capacity to provide informed consent, a parent or legal guardian may provide informed consent on the patient's behalf; and
- (6) Has received written documentation from a physician that the patient meets the requirements of this subchapter.

History. Acts 2015, No. 374, § 1.

20-15-2105. Availability.

A manufacturer of an investigational drug, biological product, or device may, but is not required to, make its investigational drug, biological product, or device available to eligible patients under this subchapter.

History. Acts 2015, No. 374, § 1.

20-15-2106. Costs — Definition.

(a) A manufacturer of an investigational drug, biological product, or device may:

- (1) Provide an investigational drug, biological product, or device to an eligible patient without receiving compensation; or
- (2)(A) Require an eligible patient to pay the costs associated with the manufacture of the investigational drug, biological product, or device.
(B) As used in this section, "costs associated with the manufacture of the investigational drug, biological product, or device" means the

actual out-of-pocket costs incurred in providing the investigational drug, biological product, or device to the patient in the specific case.

(b) If a patient dies while being treated by an investigational drug, biological product, or device, the patient's heirs are not liable for any outstanding debt to the manufacturer related to the investigational drug, biological product, or device.

History. Acts 2015, No. 374, § 1.

20-15-2107. Insurance coverage.

An insurance company:

(1) May, but is not required to, provide coverage for an investigational drug, biological product, or device; and

(2) Shall not deny coverage for an item or service that is otherwise covered by an insurance contract between the eligible person and an insurance company.

History. Acts 2015, No. 374, § 1.

20-15-2108. Prohibited sanctions.

The recommendation, prescription, treatment, or participation in the treatment of a terminal illness with an investigational drug, biological product, or device shall not permit:

(1) A licensing board to revoke a license, fail to renew a license, or take any other action against a physician's license;

(2) A state agency or licensing board to revoke a license, fail to renew a license, or take any other action against:

(A) A medical professional licensed under state law; or

(B) A hospital licensed under § 20-9-213; or

(3) An action against a hospital's Medicare certification.

History. Acts 2015, No. 374, § 1.

20-15-2109. Remedy.

The counseling, advice, or recommendation by a medical professional who is licensed under state law is not a violation of this subchapter.

History. Acts 2015, No. 374, § 1.

20-15-2110. Immunity.

(a) Except in the case of gross negligence or willful misconduct, a person or entity that manufactures, imports, distributes, prescribes, dispenses, administers, or is otherwise involved in the care of an eligible patient using an investigational drug, biological product, or device is immune from civil liability for any loss, damage, or injury arising out of, relating to, or resulting from the investigational drug,

biological product, or device so long as the person or entity is substantially complying in good faith with this subchapter.

(b) This subchapter does not require a medical professional who is licensed under the laws of this state to counsel, advise, prescribe, dispense, administer, or otherwise be involved in the care of an eligible patient using an investigational drug, biological product, or device.

(c) This subchapter does not require a hospital licensed under § 20-9-213 to provide any service related to an investigational drug, biological product, or device.

History. Acts 2015, No. 374, § 1.

20-15-2111. Medicaid coverage.

This subchapter does not require the Department of Human Services or the Arkansas Medicaid Program to provide additional coverage for an investigational drug, biological product, or device.

History. Acts 2015, No. 374, § 1.

SUBCHAPTER 22 — TASK FORCE ON ALPHA-GAL

SECTION.

20-15-2201. Findings — Purpose.

20-15-2202. Task Force on Alpha-gal —
Creation.

SECTION.

20-15-2203. Task Force on Alpha-gal —
Duties.

A.C.R.C. Notes. Identical Acts 2016 (3rd Ex. Sess.), Nos. 2 and 3, § 1, provided:

“(a) The General Assembly finds:

“(1) State government provides vital functions that impact the lives of Arkansas citizens on a daily basis;

“(2) While these functions are important, it is equally important to ensure that state government operates efficiently and effectively to eliminate unnecessary spending of tax dollars and provide timely and quality services to Arkansas citizens; and

“(3) Issues such as the administrative organization of a governmental entity, the appointment structure of a governmental entity’s governing board, and extraneous duties assigned to governmental entities hamper the operation of state government and result in unnecessary expenses and delays in the provision of state services.

“(b) It is the intent of this act to amend provisions of law applicable to certain agencies, task forces, committees, and commission to promote efficiency and ef-

fectiveness in the operations of state government as a whole.”

Acts 2017, No. 570, § 1, provided: “Legislative intent. It is the intent of the General Assembly to reenact the Task Force on Alpha-gal that was repealed by Act 2017, No. 264, § 4, and to update the Task Force on Alpha-gal.”

Effective Dates. Identical Acts 2016 (3rd Ex. Sess.), Nos. 2 and 3, § 129: May 23, 2016. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act revises the membership and duties of certain agencies, task forces, committees, and commissions and repeals other governmental entities; that these revisions and repeals of governmental entities impact the expenses and operations of state government; and that the provisions of this act should become effective as soon as possible to allow for implementation of the new provisions in advance of the upcoming fiscal year. Therefore, an emergency is declared to exist, and this act being immediately necessary for the

preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of

the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

20-15-2201. Findings — Purpose.

(a) The General Assembly finds:

(1) Alpha-gal allergies are a reaction to galactose-alpha-1, 3-galactose, when the body is overloaded with immunoglobulin E antibodies on contact with the galactose carbohydrate;

(2) Bites from the lone star tick, which transfer this carbohydrate to the victim, have been implicated in the development of this delayed allergic response which is triggered by the consumption of mammalian meat products;

(3) Alpha-gal allergies most often occur in the central and southern states such as Arkansas, where the lone star tick is more prevalent;

(4) A typical allergic reaction to Alpha-gal has a delayed onset, occurring four to eight (4-8) hours after the consumption of mammalian meat products, instead of the typical rapid onset with most food allergies;

(5) Since the reaction to eating mammal meat is delayed by several hours, the proper diagnosis is often missed or the patient is misdiagnosed;

(6) People who are affected by Alpha-gal have to be constantly vigilant about the ingredients they consume, because an allergic reaction can be severe and life-threatening; and

(7) As doctors are not required to report the number of patients suffering with Alpha-gal, the true number of affected individuals is unknown.

(b) The purpose of this subchapter is to:

(1) Promote awareness and encourage efforts to treat Alpha-gal in the state; and

(2) Ensure food safety for individuals with Alpha-gal allergies through better food labeling.

(c) This section shall expire on December 31, 2018.

History. Acts 2015, No. 1247, § 1; 2016 (3rd Ex. Sess.), No. 2, § 41; 2016 (3rd Ex. Sess.), No. 3, § 41; 2017, No. 264, § 4; reen. 2017, No. 570, § 2.

Publisher's Notes. This section formerly provided for its expiration on December 31, 2016, and Acts 2017, No. 264, § 4 repealed this section accordingly. The section was reenacted as amended by Acts 2017, No. 570, § 2.

Amendments. The 2016 (3rd Ex. Sess.) amendment by identical acts Nos. 2 and 3 added (c).

The 2017 amendment by No. 570 added (b)(2); redesignated part of former (b) as (b)(1); and substituted "2018" for "2016" in (c).

20-15-2202. Task Force on Alpha-gal — Creation.

- (a) The Task Force on Alpha-gal is created.
- (b) The task force shall be composed of the following seventeen (17) members:
 - (1) One (1) senator appointed by the President Pro Tempore of the Senate;
 - (2) Two (2) members of the House of Representatives appointed by the Speaker of the House of Representatives;
 - (3) The Director of the Department of Health or his or her designee, serving as an ex officio, nonvoting member;
 - (4) The Insurance Commissioner or his or her designee, serving as an ex officio, nonvoting member;
 - (5) The Secretary of the Arkansas Agriculture Department or his or her designee, serving as an ex officio, nonvoting member;
 - (6) Three (3) members who are employed by the Department of Health and designated by the Director of the Department of Health;
 - (7) One (1) member who is designated by the Arkansas Hospitality Association, Inc.;
 - (8) One (1) member who is designated by the Arkansas State Board of Nursing;
 - (9) One (1) member who is designated by the Arkansas Pharmacist's Association;
 - (10) One (1) member who is designated by the American Academy of Allergy, Asthma and Immunology;
 - (11) One (1) member who is designated by the American College of Allergy, Asthma and Immunology;
 - (12) Two (2) members who are designated by the Division of Agriculture of the University of Arkansas; and
 - (13) One (1) member who is a patient with a diagnosis of Alpha-gal allergies and who is appointed by the Speaker of the House of Representatives.
- (c) The terms of the legislative members of the task force shall expire on December 31, 2018.
- (d) Nonlegislative members shall serve at the pleasure of the organizations they represent.
- (e) Vacancies on the task force shall be filled in the same manner as provided for the initial appointment.
- (f) The chair shall be one (1) of the legislative members of the task force and shall be selected by the legislative members of the task force.
- (g) The task force shall meet as often as is deemed necessary by the chair.
- (h) The members of the task force shall serve without compensation and shall not receive per diem, mileage, or stipends.
- (i) The task force shall receive staff support from the Bureau of Legislative Research.
- (j) This section shall expire on December 31, 2018.

History. Acts 2015, No. 1247, § 1; 2016 (3rd Ex. Sess.), No. 2, § 42; 2016 (3rd Ex. Sess.), No. 3, § 42; 2017, No. 264, § 4; reen. 2017, No. 570, § 2.

Publisher's Notes. This section formerly provided for its expiration on December 31, 2016, and Acts 2017, No. 264, § 4 repealed this section accordingly. The section was reenacted as amended by Acts 2017, No. 570, § 2.

Amendments. The 2016 (3rd Ex. Sess.) amendment by identical acts Nos. 2 and 3 deleted former (h) and redesignated former (i) and (j) as present (h) and (i); and added present (j).

The 2017 amendment by No. 570 substituted “seventeen (17) members” for “sixteen (16) members” in the introductory language of (b); added (b)(13); and substituted “2018” for “2016” in (c) and (j).

20-15-2203. Task Force on Alpha-gal — Duties.

(a) The Task Force on Alpha-gal shall make recommendations designed to improve and increase knowledge and treatment throughout the state for Alpha-gal, especially for emergency room healthcare professionals.

(b) The task force shall submit a report to the Legislative Council, the Senate Committee on Public Health, Welfare, and Labor, and the House Committee on Public Health, Welfare, and Labor no later than October 1 annually.

(c) This section shall expire on December 31, 2018.

History. Acts 2015, No. 1247, § 1; 2016 (3rd Ex. Sess.), No. 2, § 43; 2016 (3rd Ex. Sess.), No. 3, § 43; 2017, No. 264, § 4; reen. 2017, No. 570, § 2.

Publisher's Notes. This section formerly provided for its expiration on December 31, 2016, and Acts 2017, No. 264, § 4 repealed this section accordingly. The section was reenacted as amended by Acts 2017, No. 570, § 2.

Amendments. The 2016 (3rd Ex. Sess.) amendment by identical acts Nos. 2 and 3 added (c).

The 2017 amendment by No. 570 substituted “October 1 annually” for “October 1, 2016” at the end of (b); and substituted “2018” for “2016” in (c).

CHAPTER 16

REPRODUCTIVE HEALTH

SUBCHAPTER.

1. GENERAL PROVISIONS.
2. ARKANSAS REPRODUCTIVE HEALTH MONITORING SYSTEM.
3. ARKANSAS FAMILY PLANNING ACT.
4. REPRODUCTIVE HEALTH INFORMATION.
5. SEXUALLY TRANSMITTED DISEASES.
6. ABORTION GENERALLY.
7. ABORTION — VIABLE FETUS.
8. ABORTION — PARENTAL INVOLVEMENT ENHANCEMENT ACT.
9. WOMAN'S RIGHT TO KNOW ACT OF 2001. [REPEALED.]
10. HUMAN CLONING.
11. UNBORN CHILD PAIN AWARENESS AND PREVENTION ACT.
12. PARTIAL-BIRTH ABORTION BAN ACT.
13. ARKANSAS HUMAN HEARTBEAT PROTECTION ACT.
14. PAIN-CAPABLE UNBORN CHILD PROTECTION ACT.
15. ABORTION-INDUCING DRUGS SAFETY ACT.
16. ADVANCING WOMEN'S HEALTH ACT OF 2015.
17. WOMAN'S RIGHT-TO-KNOW ACT.

SUBCHAPTER

- 18. ARKANSAS UNBORN CHILD PROTECTION FROM DISMEMBERMENT ABORTION ACT.
- 19. SEX DISCRIMINATION BY ABORTION PROHIBITION ACT.

SUBCHAPTER 1 — GENERAL PROVISIONS

SECTION.

- 20-16-101. Authorization to continue the Mississippi County Midwife Program.
- 20-16-102. Authorization to distribute or-

gan and tissue donation information for a fatal fetal diagnosis.

Effective Dates. Acts 1989, No. 99 (1st Ex. Sess.), § 41: July 1, 1989. Emergency clause provided: "It is hereby found and determined by the Seventy-Seventh General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness of this Act on July 1, 1989 is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event

of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1, 1989 could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 1989."

RESEARCH REFERENCES

ALR. State regulation of midwifery. 59 A.L.R.4th 929.

20-16-101. Authorization to continue the Mississippi County Midwife Program.

The Director of the Department of Health may continue the Mississippi County Midwife Program utilizing available state and federal funding.

History. Acts 1989, No. 99 (1st Ex. Sess.), § 35.

A.C.R.C. Notes. Former § 20-16-101, concerning authorization to continue the

Mississippi County Midwife Program, is deemed to be superseded by this section. The former section was derived from Acts 1985, No. 718, § 27.

20-16-102. Authorization to distribute organ and tissue donation information for a fatal fetal diagnosis.

(a) A physician may distribute information regarding organ and tissue donation to a pregnant woman when the unborn fetus is diagnosed with a fatal fetal condition which will result in death within three (3) months of birth.

(b) The information shall include:

(1) The telephone number, address, and website information for the Arkansas Regional Organ Recovery Agency, Inc.; and

- (2) The steps in the process of organ and tissue donation.
- (c) The physician shall document in writing that the information has been distributed to the pregnant woman.

History. Acts 2015, No. 823, § 1.

SUBCHAPTER 2 — ARKANSAS REPRODUCTIVE HEALTH MONITORING SYSTEM

SECTION.

- 20-16-201. Establishment — Purpose.
- 20-16-202. Definition.
- 20-16-203. Advisory commission — Members — Functions.
- 20-16-204. [Repealed.]
- 20-16-205. Medical director — Appointment — Powers and duties.
- 20-16-206. Authority to contract for information.
- 20-16-207. Information confidential — Exception.
- 20-16-208. Furnishing of information by hospitals.

SECTION.

- 20-16-209. Furnishing of information by physician, clinic, etc.
- 20-16-210. Intergovernmental agreements.
- 20-16-211. Funding and implementation.
- 20-16-212. Reports.
- 20-16-213. Rendering of patient care and regulatory activity prohibited.
- 20-16-214. No actionable right, presumptions, or findings created.

Effective Dates. Acts 1997, No. 250, § 258: Feb. 24, 1997. Emergency clause provided: “It is hereby found and determined by the General Assembly that Act 1211 of 1995 established the procedure for all state boards and commissions to follow regarding reimbursement of expenses and stipends for board members; that this act amends various sections of the Arkansas Code which are in conflict with the Act 1211 of 1995; and that until this cleanup act becomes effective conflicting laws will exist. Therefore an emergency is declared

to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto.”

20-16-201. Establishment — Purpose.

- (a) The Arkansas Reproductive Health Monitoring System is established and is to be administered within Arkansas Children’s Hospital.
- (b) The purpose of the system is to collect and analyze data from a number of sources to describe trends in the occurrence of reproductive endpoints, including without limitation congenital anomalies, fetal deaths, stillbirths, and premature births, and to investigate the causes of unexpected reproductive endpoints.

History. Acts 1985, No. 214, § 1; A.S.A. 1947, § 82-4608; Acts 2015, No. 1062, § 1.

Amendments. The 2015 amendment, in (b), substituted “including without limi-

tation” for “such as”, “deaths” for “death”, “stillbirths, and premature births” for “developmental disorders, etc.”, and “investigate the causes of unexpected reproduc-

tive endpoints” for “correlate those trends and investigate and report on the suspected causes of unexpected deviations in those trends”.

20-16-202. Definition.

As used in this subchapter, “commission” means the advisory commission established in § 20-16-203.

History. Acts 1985, No. 214, § 3; A.S.A. 1947, § 82-4610; Acts 2015, No. 1062, § 1. deleted (1); deleted designation (2); and deleted (3).

Amendments. The 2015 amendment

20-16-203. Advisory commission — Members — Functions.

(a) The Arkansas Reproductive Health Monitoring System shall be administered with the advice of an advisory commission appointed to one-year renewable terms by the Medical Director of the Arkansas Reproductive Health Monitoring System.

(b) The functions of the commission are to:

(1) Advise the medical director as to the adequacy of policies, procedures, and performance of the system;

(2) Promote the purposes of the system and assist in identification of appropriate funding sources;

(3) Promote interagency cooperation toward the goals of the system; and

(4) Review mechanisms ensuring the maintenance of the confidentiality of personal data.

(c) The commission shall be composed of the following state agency members, professional members, and public members:

(1) The Medical Director of Arkansas Children’s Hospital;

(2) The Chancellor of the University of Arkansas for Medical Sciences;

(3) The Director of the Department of Health;

(4) The Director of the National Center for Toxicological Research;

(5) One (1) representative of the Arkansas chapter of the American Academy of Pediatrics;

(6) One (1) representative of the Arkansas Society for Obstetrics and Gynecology;

(7) One (1) representative of the Arkansas Hospital Association, Inc.;

(8) Two (2) consumer representatives;

(9) One (1) member from the House Committee on Public Health, Welfare, and Labor and one (1) member from the Senate Committee on Public Health, Welfare, and Labor; and

(10) Up to six (6) additional members at large may be appointed.

(d) Members of the commission who are not employees of the state may receive expense reimbursement in accordance with § 25-16-901 et seq.

History. Acts 1985, No. 214, §§ 4, 11; 1997, No. 250, § 188; 1999, No. 1164, A.S.A. 1947, §§ 82-4611, 82-4618; Acts 1997, No. 250, § 173; 2015, No. 1062, § 1.

Amendments. The 2015 amendment substituted “the Arkansas Reproductive Health Monitoring System” for “Arkansas Children’s Hospital” following “Medical Director of” in (a); deleted former (b)(2),

(b)(5), (c)(4), (c)(5), (c)(7), and (c)(11) and redesignated the remaining subdivisions accordingly; and substituted “six (6)” for “four (4)” in present (c)(10).

20-16-204. [Repealed.]

Publisher’s Notes. This section, concerning the technical advisory board, was repealed by Acts 2015, No. 1062, § 2. The

section was derived from Acts 1985, No. 214, §§ 5, 11; A.S.A. 1947, §§ 82-4612, 82-4618; Acts 1997, No. 250, § 189.

20-16-205. Medical director — Appointment — Powers and duties.

(a) The Arkansas Reproductive Health Monitoring System shall be administered by a medical director appointed by the Medical Director of Arkansas Children’s Hospital from among the professional staff of Arkansas Children’s Hospital.

(b) The Medical Director of the Arkansas Reproductive Health Monitoring System shall:

- (1) Supervise the work of the system and administer the budget;
- (2) Appoint and remove such other employees as may be necessary to perform the duties and responsibilities of the system; and
- (3) Select and retain the services of consultants whose advice is considered necessary to carry out the system’s mandate.

History. Acts 1985, No. 214, § 2; A.S.A. 1947, § 82-4609; Acts 2015, No. 1062, § 3.

Amendments. The 2015 amendment substituted “Medical director” for “Director” in the section heading; substituted

the first occurrence of “medical director” for “director” in (a); and substituted “The Medical Director of the Arkansas Reproductive Health Monitoring System” for “The director” in (b).

20-16-206. Authority to contract for information.

(a) The Arkansas Reproductive Health Monitoring System is expressly authorized to contract for the production of any information which the Medical Director of the Arkansas Reproductive Health Monitoring System determines to be relevant to monitoring reproductive health.

(b) Information shared under this section includes, but is not limited to, information identified by name or other personal identifier, including information concerning any system by which such data or information is identified or classified if required to decipher the information.

History. Acts 1985, No. 214, § 6; A.S.A. 1947, § 82-4613; Acts 2015, No. 1062, § 4.

Amendments. The 2015 amendment, in (a), substituted “the Medical Director of

the Arkansas Reproductive Health Monitoring System” for “its technical advisory board” and deleted “from any department or agency of the state” at the end.

20-16-207. Information confidential — Exception.

The Arkansas Reproductive Health Monitoring System is expressly exempted and prohibited from supplying any information by individual name or other personal identifier or in a form other than a statistical report or other appropriate form which protects the confidentiality of individuals except to any state agency or department which originally supplied the information to the system unless both the originating agency and the system grant release of this information for a specific purpose.

History. Acts 1985, No. 214, § 7; A.S.A. 1947, § 82-4614.

20-16-208. Furnishing of information by hospitals.

All hospitals with patient records containing information pertaining to reproduction and development are required to share information in those records with the Arkansas Reproductive Health Monitoring System.

History. Acts 1985, No. 214, § 8; A.S.A. 1947, § 82-4615; Acts 2015, No. 1062, § 5. **Amendments.** The 2015 amendment deleted designation (a); and deleted (b).

20-16-209. Furnishing of information by physician, clinic, etc.

- (a) Any physician, clinic, person, or organization may provide information relative to reproductive health to the Arkansas Reproductive Health Monitoring System.
- (b) No liability of any kind for damages or other relief shall arise or be enforced against any person or organization for having provided the information or for having released or published the findings of the system in order to reduce morbidity or mortality or to advance medical research or medical education.

History. Acts 1985, No. 214, § 9; A.S.A. 1947, § 82-4616.

20-16-210. Intergovernmental agreements.

The Arkansas Reproductive Health Monitoring System shall have the power to enter into agreements with other states and the Centers for Disease Control and Prevention consistent with the requirements and restrictions of this subchapter in order to obtain relevant information for the system concerning Arkansas residents who receive health-related services outside the state.

History. Acts 1985, No. 214, § 10; A.S.A. 1947, § 82-4617; Acts 2015, No. 1062, § 6. **Amendments.** The 2015 amendment substituted “other states” for “neighboring states”.

20-16-211. Funding and implementation.

(a) The Arkansas Reproductive Health Monitoring System shall have the power to receive and expend grants, donations, and funds from public and private sources to carry out its responsibilities under this subchapter.

(b) Arkansas Children's Hospital is not required to implement this system unless sufficient funds are available as determined by the Medical Director of Arkansas Children's Hospital.

(c) The system may be implemented in stages or phases.

History. Acts 1985, No. 214, § 13;
A.S.A. 1947, § 82-4620.

20-16-212. Reports.

The Arkansas Reproductive Health Monitoring System shall periodically prepare reports of its findings for dissemination to appropriate agencies and interested persons.

History. Acts 1985, No. 214, § 14;
A.S.A. 1947, § 82-4621.

20-16-213. Rendering of patient care and regulatory activity prohibited.

The Arkansas Reproductive Health Monitoring System is expressly prohibited from rendering patient care, promulgating any rule or regulation, or engaging in any regulatory activity.

History. Acts 1985, No. 214, § 13;
A.S.A. 1947, § 82-4620.

20-16-214. No actionable right, presumptions, or findings created.

(a) Persons other than the state or Arkansas Reproductive Health Monitoring System shall not acquire any actionable right by virtue of this subchapter.

(b) A determination by the system that a source is suspected of causing adverse reproductive health outcomes shall not create by reason thereof any presumption of law or finding of a fact which shall inure to, or be for, the benefit of any person other than the state.

History. Acts 1985, No. 214, § 12;
A.S.A. 1947, § 82-4619.

SUBCHAPTER 3 — ARKANSAS FAMILY PLANNING ACT

SECTION.

20-16-301. Title.

20-16-302. Legislative declaration.

20-16-303. Definitions.

SECTION.

20-16-304. Public policy — Availability of procedures, supplies, and information — Exceptions.

SECTION.

20-16-305. Liability for surgical sterilization.

Cross References. Abortion, § 5-61-101.

RESEARCH REFERENCES

ALR. Administering or prescribing birth control pills or devices. 9 A.L.R.4th 372.	Ark. L. Rev. Note, Wilbur v. Kerr: The Tort of Wrongful Birth in Arkansas, 36 Ark. L. Rev. 429.
Am. Jur. 1 Am. Jur. 2d, Abortion & B.C., §§ 2, 5.	C.J.S. 1 C.J.S., Abortion & B.C., §§ 2, 3.

20-16-301. Title.

This subchapter shall be known and may be cited as the “Arkansas Family Planning Act”.

History. Acts 1973, No. 235, § 1; A.S.A. 1947, § 82-3101.

20-16-302. Legislative declaration.

It is the declaration of the General Assembly that:

- (1) Continuing population growth either causes or aggravates many social, economic, and environmental problems, both in this state and in the nation;
- (2) Contraceptive procedures, supplies, and information as to and procedures for voluntary sterilization are not sufficiently available as a practical matter to many persons in this state;
- (3) It is desirable that inhibitions and restrictions be eliminated so that all persons desiring and needing contraceptive procedures, supplies, and information shall have ready and practicable access thereto through legally recognized channels; and
- (4) Section 20-16-304 sets forth the policy and authority of this state, its political subdivisions, and all agencies and institutions thereof, including prohibitions against restrictions, with respect to contraceptive procedures, supplies, and information.

History. Acts 1973, No. 235, § 3; A.S.A. 1947, § 82-3103.

20-16-303. Definitions.

As used in this subchapter:

- (1) “Contraceptive procedures” means any medically accepted procedures designed to prevent conception; and

(2) "Contraceptive supplies" means those medically approved items designed to prevent conception through chemical, mechanical, or other means.

History. Acts 1973, No. 235, § 2; A.S.A. 1947, § 82-3102.

20-16-304. Public policy — Availability of procedures, supplies, and information — Exceptions.

It shall be the policy and authority of this state that:

(1) All medically acceptable contraceptive procedures, supplies, and information shall be available through legally recognized channels to each person desirous of the procedures, supplies, and information regardless of sex, race, age, income, number of children, marital status, citizenship, or motive;

(2) Medical procedures for permanent sterilization, when performed by a physician on a requesting and consenting person eighteen (18) years of age or older, or less than eighteen (18) years of age if legally married, be consistent with public policy;

(3) Dissemination of medically acceptable contraceptive information in this state and in state and county health and welfare departments, in medical facilities, at institutions of higher education, and at other agencies and instrumentalities of this state be consistent with public policy;

(4) Nothing in this subchapter shall prohibit a physician, pharmacist, or any other authorized paramedical personnel from refusing to furnish any contraceptive procedures, supplies, or information; and

(5) No private institution or physician, nor any agent or employee of the institution or physician, nor any employee of a public institution acting under directions of a physician, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when the refusal is based upon religious or conscientious objection. No such institution, employee, agent, or physician shall be held liable for the refusal.

History. Acts 1973, No. 235, § 4; A.S.A. 1947, § 82-3104.

RESEARCH REFERENCES

ALR. Propriety of Pharmacy and Pharmacist's Refusal to Fill Prescription for Contraceptives. 41 A.L.R.6th 555.

20-16-305. Liability for surgical sterilization.

Subject to the rules of law applicable generally to negligence, no physician or surgeon licensed by this state shall be liable civilly or criminally by reason of having performed surgical sterilization authorized by the provisions of this subchapter upon any person in this state.

History. Acts 1973, No. 235, § 5; A.S.A. 1947, § 82-3105.

SUBCHAPTER 4 — REPRODUCTIVE HEALTH INFORMATION

SECTION.

- 20-16-401. Department of Health.
- 20-16-402. Information from state agencies.
- 20-16-403. Information from neighboring states.
- 20-16-404. Information sharing.

SECTION.

- 20-16-405. Authority of physician to provide information.
- 20-16-406. No actionable right created.
- 20-16-407. No legal presumption or finding of fact created.
- 20-16-408. Nonliability.

Cross References. Confidentiality of information and records used in medical research, § 20-9-304.

RESEARCH REFERENCES

C.J.S. 1 C.J.S., Abortion & B.C., § 7 et seq.

20-16-401. Department of Health.

This subchapter shall not be applicable to the Department of Health.

History. Acts 1983, No. 773, § 7; A.S.A. 1947, § 82-4607.

20-16-402. Information from state agencies.

- (a)(1) Any bona fide appropriately licensed medical facility, including, but not limited to, a county hospital, participating in recognized research in Arkansas and the Centers for Disease Control and Prevention is expressly authorized to contract for the production of any information relevant to monitoring reproductive health.
- (2) Information acquired under this subsection includes, but is not limited to, information identified by name or other personal identifying information including the method by which the information was compiled or tabulated.
- (b) The University of Arkansas for Medical Sciences, Arkansas Children’s Hospital, other participating medical facilities as described in subsection (a) of this section, and the Centers for Disease Control and Prevention are expressly prohibited from supplying any information obtained pursuant to subsection (a) of this section by individual name or other personal identifying information or in a form other than a statistical report or other appropriate form which protects the confidentiality of individuals.

(c) Information obtained pursuant to subsection (a) of this section may be returned to any state agency or department from which it was originally obtained.

History. Acts 1983, No. 773, §§ 1, 3; in (a)(1), substituted “a county hospital”
A.S.A. 1947, §§ 82-4601, 82-4603; Acts for “county hospitals” and deleted “from
2015, No. 1062, § 7. any department or agency of the state” at
the end.

Amendments. The 2015 amendment,

20-16-403. Information from neighboring states.

The University of Arkansas for Medical Sciences, Arkansas Children’s Hospital, and the Centers for Disease Control and Prevention shall have the power to enter into agreements with neighboring states consistent with the requirements and restrictions of this subchapter in order to obtain relevant information concerning Arkansas residents who receive health-related services outside the state.

History. Acts 1983, No. 773, § 5; A.S.A.
1947, § 82-4605.

20-16-404. Information sharing.

All hospitals with pediatric, obstetric, or spontaneous abortion patient records may under this subchapter contract to share information in those records with the University of Arkansas for Medical Sciences, Arkansas Children’s Hospital, other bona fide licensed medical facilities, and the Centers for Disease Control and Prevention.

History. Acts 1983, No. 773, § 2; A.S.A.
1947, § 82-4602.

20-16-405. Authority of physician to provide information.

Any physician, clinic, person, or organization may under this subchapter contract to provide information relative to reproductive health to the University of Arkansas for Medical Sciences, Arkansas Children’s Hospital, and the Centers for Disease Control and Prevention.

History. Acts 1983, No. 773, § 4; A.S.A.
1947, § 82-4604.

20-16-406. No actionable right created.

Persons other than the state, the University of Arkansas for Medical Sciences, Arkansas Children’s Hospital, and the Centers for Disease Control and Prevention shall not acquire any actionable right by virtue of this subchapter.

History. Acts 1983, No. 773, § 6; A.S.A.
1947, § 82-4606.

20-16-407. No legal presumption or finding of fact created.

A determination by a study done under this subchapter that a source is suspected of causing adverse fetal or neonatal health outcomes shall not create by reason thereof any presumption of law or finding of a fact which shall inure to or be for the benefit of any person other than the state.

History. Acts 1983, No. 773, § 6; A.S.A. 1947, § 82-4606.

20-16-408. Nonliability.

No liability of any kind for damages or other relief shall arise or be enforced against any person or organization by reason of having provided information pursuant to this subchapter or by reason of having released or published the findings of research studies in order to reduce morbidity or mortality or to advance medical research or medical education based on information shared under this subchapter.

History. Acts 1983, No. 773, § 4; A.S.A. 1947, § 82-4604.

SUBCHAPTER 5 — SEXUALLY TRANSMITTED DISEASES

SECTION.

- 20-16-501. Notification required.
- 20-16-502. Notification — Contents.
- 20-16-503. Notification — Physician’s duty.
- 20-16-504. Notification — Information confidential.

SECTION.

- 20-16-505. Notification — Authority to regulate.
- 20-16-506. Failure to notify — Penalty.
- 20-16-507. Testing of pregnant women required.
- 20-16-508. Treatment of minors.

Preambles. Acts 1947, No. 71, contained a preamble which read: “Whereas, syphilis may be transmitted from the infected mother to the unborn child and the fact that such congenital syphilis can be

prevented if the disease is recognized in the mother and prompt adequate treatment is given”
Effective Dates. Acts 1947, No. 71, § 5: July 1, 1947.

RESEARCH REFERENCES

ALR. Tort liability for infliction of venereal disease. 40 A.L.R.4th 1089.
Physician’s tort liability for unauthor-

ized disclosure of confidential information about patient. 48 A.L.R.4th 668.

20-16-501. Notification required.

(a) Any person who determines by laboratory examination that a specimen derived from a human body yields microscopical, cultural, serological, or other evidence suggestive of those sexually transmitted diseases enumerated in subsection (b) of this section shall notify the

HIV/STD/Hepatitis C Section of the Department of Health of such findings.

(b) Notice shall be given for the following conditions or diseases:

- (1) Syphilis;
- (2) Gonorrhea;
- (3) Chancroid;
- (4) Lymphogranuloma Venereum; and
- (5) Granuloma Inguinale.

(c) Specific reportable sexually transmitted disease tests are:

- (1) All reactive or positive and weakly reactive or doubtful serological tests for syphilis;
- (2) All reactive or positive and weakly reactive or doubtful spinal fluid serological tests for syphilis;
- (3) All positive darkfield microscopic tests for treponema pallidum;
- (4) All positive gonococcal smears or cultures; and
- (5) All positive tests indicating the presence of Ducrey's bacillus, known as chancroid, or Donovan bodies, known as Granuloma Inguinale, or filterable virus, known as Lymphogranuloma Venereum.

History. Acts 1973, No. 60, §§ 1, 3; A.S.A. 1947, §§ 82-632, 82-634; Acts 2007, No. 827, § 160.

RESEARCH REFERENCES

Ark. L. Rev. Note, Baker v. State: The Arkansas Physician-Patient Privilege Re-examined, 36 Ark. L. Rev. 658.

CASE NOTES

Cited: Baker v. State, 276 Ark. 193, 637 S.W.2d 522 (1982).

20-16-502. Notification — Contents.

(a) Notification shall contain the total number of tests performed by type, number of negative specimens, and number of positive or doubtful specimens.

(b) Notification of positive or doubtful test results shall contain the name, age, sex, and address of the person from whom the specimen was obtained and the name and address of the physician for whom the examination or test was performed.

(c) Notification also shall contain the name of the test performed, the date the test was performed, and the result of the test performed.

(d) Notification shall be submitted in writing and in such form and manner as prescribed by regulations of the Infectious Disease Branch of the Department of Health.

History. Acts 1973, No. 60, § 2; A.S.A. 1947, § 82-633.

20-16-503. Notification — Physician's duty.

Laboratory reporting under §§ 20-16-501 — 20-16-506 shall in no way release the attending physician from his or her responsibility to report cases of sexually transmitted diseases to the HIV/STD/Hepatitis C Section of the Department of Health.

History. Acts 1973, No. 60, § 7; A.S.A. 1947, § 82-638; Acts 2007, No. 827, § 161.

20-16-504. Notification — Information confidential.

All laboratory notifications required by §§ 20-16-501 — 20-16-506 are confidential and shall not be open for inspection by anyone except public health personnel.

History. Acts 1973, No. 60, § 4; A.S.A. 1947, § 82-635.

CASE NOTES

Cited: Baker v. State, 276 Ark. 193, 637 S.W.2d 522 (1982).

20-16-505. Notification — Authority to regulate.

The Infectious Disease Branch of the Department of Health may enact each rule and regulation as is necessary to assure compliance with §§ 20-16-501 — 20-16-506.

History. Acts 1973, No. 60, § 6; A.S.A. 1947, § 82-637.

20-16-506. Failure to notify — Penalty.

Failure to give notice as provided in §§ 20-16-501 — 20-16-505 shall be a violation and upon conviction shall be punishable by a fine of not less than ten dollars (\$10.00) nor more than twenty-five dollars (\$25.00).

History. Acts 1973, No. 60, § 5; A.S.A. 1947, § 82-636; Acts 2005, No. 1994, § 112.

20-16-507. Testing of pregnant women required.

(a)(1)(A) Every physician and healthcare provider attending pregnant women in this state for conditions relating to their pregnancy shall, in the case of every woman so attended, take or cause to be taken a sample of venous blood or other approved specimen of the woman as early as reasonably possible in the pregnancy or, if not attended prenatally, at the time of delivery, and shall submit the sample to an approved laboratory for:

- (i) A standard serological test for syphilis;
- (ii) A standard test for human immunodeficiency virus; and
- (iii) A standard test for Hepatitis B.

(B) If for any reason the pregnant woman is not tested for syphilis, human immunodeficiency virus, or Hepatitis B, that fact shall be recorded in the patient's records, which, if based upon the refusal of the patient, shall relieve the physician of any responsibility under this subsection.

(2) Every other person authorized by law to attend or to provide medical treatment to pregnant women in this state but not permitted by law to take blood samples shall cause a sample of blood or other approved specimen of the pregnant woman to be taken as early as reasonably possible in the pregnancy or, if not attended prenatally, at the time of delivery, by or under the direction of a physician licensed to practice medicine and surgery and have the sample submitted to an approved laboratory for:

- (A) A standard serological test for syphilis;
- (B) A standard test for human immunodeficiency virus; and
- (C) A standard test for Hepatitis B.

(3) Every physician described in subdivision (a)(1) of this section and every person described in subdivision (a)(2) of this section shall:

(A) Inform each pregnant woman whom he or she is attending of the fact that syphilis, human immunodeficiency virus, and Hepatitis B may be transmitted from an infected mother to the fetus or unborn child and that these infections may be prevented if the maternal infection is recognized and treated; and

(B) Provide counseling and instruction for human immunodeficiency virus in a manner prescribed by the Department of Health based upon contemporary state and federal standards.

(b) For the purpose of this section, a standard serological test shall be a test for syphilis, human immunodeficiency virus, and Hepatitis B, approved or authorized by the Centers for Disease Control and Prevention, and approved by the Director of the Department of Health and shall be made at the division's laboratory or at another laboratory approved to make such tests.

(c) All records, reports, data, or other information collected or maintained under this section that identifies or could be used to identify any individual patient, provider, or institution shall be confidential, shall not be subject to discovery pursuant to the Arkansas Rules of Civil Procedure or the Freedom of Information Act of 1967, § 25-19-101 et seq. However, this subsection shall not affect the reports required to be submitted to the department under other laws and rules and regulations.

History. Acts 1947, No. 71, §§ 1-3; A.S.A. 1947, §§ 82-607 — 82-609; Acts 1997, No. 963, § 1.

20-16-508. Treatment of minors.

(a)(1) When a minor who believes himself or herself to have a sexually transmitted disease consents to the provision of medical care or surgical care or services by a hospital or public clinic or consents to the performance of medical care or surgical care or services by a physician who is licensed to practice medicine in this state, the consent:

(A) Is valid and binding as if the minor had achieved his or her majority; and

(B) Is not subject to a later disaffirmance by reason of his or her minority.

(2) The consent of a spouse, parent, guardian, or any other person standing in a fiduciary capacity to the minor shall not be necessary in order to authorize hospital care or services or medical or surgical care or services to be provided to the minor by a physician licensed to practice medicine.

(b) Upon the advice and direction of a treating physician or in the case of a medical staff any one (1) of them, a physician or member of a medical staff may inform the spouse, parent, or guardian of any minor as to the treatment given or needed but shall not be obligated to do so. The information may be given to or withheld from the spouse, parent, or guardian without the consent and over the express objection of the minor.

History. Acts 1969, No. 100, §§ 1-3; A.S.A. 1947, §§ 82-629 — 82-631; Acts 1997, No. 208, § 20; 2007, No. 827, § 162; 2009, No. 952, § 3.

A.C.R.C. Notes. Acts 1997, No. 208, § 1, as reenacted by Acts 2017, No. 255, § 1, provided: “Legislative intent and purpose. The General Assembly hereby acknowledges that many of the laws relating to individuals with disabilities are anti-

quoted, functionally outmoded, derogatory, and ambiguous or are inconsistent with more recently enacted provisions of the law. Consequently, it is the intent of the General Assembly and the purpose of this act to clarify the relevant chapters of Titles 1, 6, 9, 13, 14, 16, 17, 20, 22, 23, and 27 of the Arkansas Code of 1987 Annotated.”

SUBCHAPTER 6 — ABORTION GENERALLY

SECTION.

- 20-16-601. Refusal to perform, participate, consent, or submit.
- 20-16-602. Right to view ultrasound image prior to abortion.
- 20-16-603. Drug-induced abortions — Procedures — Penalties —

SECTION.

- Causes of action — Definitions.
- 20-16-604. Born-alive infant protection — Cause of action — Definitions.

Cross References. Abortion, Ark. Const. Amend. 68.
Abortion-Inducing Drugs Safety Act, § 20-16-1501 et seq.
Concealing birth, § 5-26-203.

Criminal abortion, § 5-61-101 et seq.
Registration and inspection of abortion clinics, § 20-9-302.
Effective Dates. Acts 2017, No. 392, § 4: Jan. 1, 2018.

RESEARCH REFERENCES

- Am. Jur.** 1 Am. Jur. 2d, Abortion & B.C., § 1 et seq. Wrongful conception or pregnancy. 89 A.L.R.4th 632.
- ALR.** Medical malpractice in performance of legal abortion. 69 A.L.R.4th 875. **C.J.S.** 1 C.J.S., Abortion & B.C., § 1 et seq.

20-16-601. Refusal to perform, participate, consent, or submit.

(a) No person shall be required to perform or participate in medical procedures which result in the termination of pregnancy. The refusal of any person to perform or participate in these medical procedures shall not be a basis for civil liability to any person nor a basis for any disciplinary or any other recriminatory action against him or her.

(b) No hospital, hospital director, or governing board shall be required to permit the termination of human pregnancies within its institution, and the refusal to permit the procedures shall not be grounds for civil liability to any person nor a basis for any disciplinary or other recriminatory action against it by the state or any person.

(c) The refusal of any person to submit to an abortion or to give consent for an abortion shall not be grounds for loss of any privileges or immunities to which the person would otherwise be entitled, nor shall submission to an abortion or the granting of consent for an abortion be a condition precedent to the receipt of any public benefits.

- History.** Acts 1969, No. 61, § 8; A.S.A. 1947, § 41-2560. *Smith v. Bentley*, 493 F. Supp. 916 (E.D. Ark. 1980). However, the plaintiffs lacked standing to challenge this section.
- Publisher's Notes.** Acts 1969, No. 61, §§ 1-7, were declared unconstitutional in

RESEARCH REFERENCES

- ALR.** Validity of state "informed consent" statutes by which providers of abortions are required to provide patient seeking abortion with certain information. 119 A.L.R.5th 315.
- U. Ark. Little Rock L.J.** Legislative Survey, Health Law, 8 U. Ark. Little Rock L.J. 583.
- Women's Reproductive Rights Concern-**

ing Abortion, and Governmental Regulation Thereof — Supreme Court Cases. 20 A.L.R. Fed. 2d 1.

CASE NOTES

Constitutionality.

Although physicians, who desired to render abortions without the restraints imposed by statute, had standing to challenge the constitutionality of § 5-61-102, they did not have standing to challenge the constitutionality of this section as this statute is not a penal statute but deals

exclusively with immunity from civil liability or loss of public benefits and, thus, this section was severable from the provisions of other statutes challenged by the physicians. *Smith v. Bentley*, 493 F. Supp. 916 (E.D. Ark. 1980).

Cited: *May v. State*, 254 Ark. 194, 492 S.W.2d 888 (1973).

20-16-602. Right to view ultrasound image prior to abortion.

(a) All physicians who use ultrasound equipment in the performance of an abortion shall inform the woman that she has the right to view the ultrasound image of her unborn child before an abortion is performed.

(b)(1) The physician shall certify in writing that the woman was offered an opportunity to view the ultrasound image and shall obtain the woman's acceptance or rejection to view the image in writing.

(2) If the woman accepts the offer and requests to view the ultrasound image, she shall be allowed to view it.

(c) The physician's certification together with the woman's signed acceptance or rejection shall be placed in the woman's medical file in the physician's office and kept for three (3) years.

(d) Any physician who fails to inform the woman that she has the right to view the ultrasound image of her unborn child before an abortion is performed or fails to allow her to view the ultrasound image upon her request may be subject to disciplinary action by the Arkansas State Medical Board.

History. Acts 2003, No. 1189, §§ 1, 2.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of to View Ultrasound Image, 26 U. Ark. Legislation, 2003 Arkansas General Assembly, Public Health and Welfare, Right Little Rock L. Rev. 465.

20-16-603. Drug-induced abortions — Procedures — Penalties — Causes of action — Definitions.

(a) As used in this section:

(1) "Abortion" means the use or prescription of an instrument, medicine, drug, or another substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died in utero as the result of natural causes, accidental trauma, or a criminal assault on the pregnant woman or her unborn child, and that causes the premature termination of the pregnancy;

(2) "Attempt to perform or induce an abortion" means an act or an omission of a statutorily required act that, under the circumstances as the physician believes them to be, constitutes a substantial step toward the performance or induction of an abortion in violation of this section;

(3) "Mifepristone" means the specific abortion-inducing drug regimen known as RU-486; and

(4) "Physician" means a natural person licensed to practice medicine in the State of Arkansas under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.

(b)(1) When mifepristone or another drug or chemical regimen is used to induce an abortion, the initial administration of the drug or

chemical shall occur in the same room and in the physical presence of the physician who prescribed, dispensed, or otherwise provided the drug or chemical to the patient.

(2) The physician who induces the abortion, or a person acting on behalf of the physician who induces the abortion, shall make all reasonable efforts to ensure that the patient returns twelve (12) to eighteen (18) days after the administration or use of mifepristone or another drug or chemical for a follow-up visit so that the physician can confirm that the pregnancy has been terminated and can assess the patient's medical condition.

(3) A brief description of the efforts made to comply with this section, including the date, time, and identification by name of the person making the efforts, shall be included in the patient's medical record.

(c) This section does not affect telemedicine practice that does not involve the use of mifepristone or another drug or chemical to induce an abortion.

(d)(1) If the Arkansas State Medical Board finds that a physician licensed by the board has violated the rules of professional conduct by performing an abortion in violation of this subchapter, the board shall revoke the physician's license.

(2) A penalty shall not be assessed against the woman upon whom the abortion is performed or attempted to be performed.

(e)(1)(A) A woman who receives an abortion, the father of the unborn child who was the subject of the abortion if the father was married to the woman who received the abortion at the time the abortion was performed, or a maternal grandparent of the unborn child may maintain an action against the person who performed the abortion in violation of this section for actual and punitive damages.

(B) A woman who attempts to receive an abortion in violation of this section may maintain an action against the person who attempted to perform the abortion for actual and punitive damages.

(2)(A) Upon petition by any citizen in the county in which an alleged violation of this section occurred or in which the defendant resides, a court may enjoin a healthcare professional who has knowingly or recklessly violated this section.

(B) An injunction under subdivision (e)(2)(A) of this section shall prevent the abortion provider from performing further abortions in violation of this section.

(f)(1) If a judgment is rendered in favor of the plaintiff who prevails in an action under subsection (e) of this section, the court shall award reasonable attorney's fees and costs in favor of the plaintiff against the defendant.

(2) If a judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall order the plaintiff to pay reasonable attorney's fees to the defendant.

(g) A pregnant woman who obtains or possesses mifepristone or another drug or chemical used for the purpose of inducing an abortion

to terminate her pregnancy shall not be subject to an action under subsection (e) of this section.

(h)(1) In a civil proceeding or action brought under this section, the court shall determine if the anonymity of a woman who receives or attempts to receive an abortion shall be preserved from public disclosure without her consent.

(2)(A) Upon determining that the woman's anonymity shall be preserved, the court shall issue an order to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard the woman's identity from public disclosure.

(B) An order under subdivision (h)(2)(A) of this section shall be accompanied by specific written findings explaining:

(i) Why the anonymity of the woman should be preserved from public disclosure;

(ii) Why the order is essential to that end;

(iii) How the order is narrowly tailored to serve that interest; and

(iv) Why no reasonable, less restrictive alternative exists.

(C) In the absence of written consent of the woman who receives or attempts to receive an abortion, anyone other than a public official who brings an action under subsection (e) of this section shall bring the action under a pseudonym.

(D) This subsection does not conceal the identity of the plaintiff or of a witness from the defendant.

(i) This section does not create or recognize a right to abortion.

History. Acts 2015, No. 139, § 1; 2015, No. 1014, § 1.

20-16-604. Born-alive infant protection — Cause of action — Definitions.

(a) As used in this section:

(1)(A) "Abortion" means the act of using or prescribing any instrument, medicine, drug, or other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child.

(B) A use, prescription, or means under this subdivision (a)(1) is not an abortion if the use, prescription, or means is performed with the intent to:

(i) Save the life or preserve the health of the unborn child;

(ii) Remove a dead unborn child caused by spontaneous abortion;

or

(iii) Remove an ectopic pregnancy;

(2) "Infant" means a child who has been completely expelled or extracted from the mother, regardless of the stage of gestational development, until thirty (30) days after the birth; and

(3) “Infant who is born alive” means the complete expulsion or extraction of an infant from a mother, regardless of the state of gestational development, who shows any evidence of life, including without limitation:

- (A) Breathing;
- (B) Heartbeat;
- (C) Umbilical cord pulsation; or
- (D) Definite movement of voluntary muscles.

(b) A physician, other healthcare professional, or other person shall not deny or deprive an infant of nourishment with the intent to cause or allow the death of the infant for any reason, including without limitation:

(1) The infant was born with a physical, intellectual, or developmental disability;

(2) The infant was not wanted by the parent or guardian; or

(3) The infant was born alive by natural or artificial means.

(c) A physician, other healthcare professional, or other person shall not deprive an infant of medically appropriate and reasonable medical care and treatment or surgical care.

(d) This section does not prevent an infant’s parent or legal guardian from refusing to give consent to medical treatment or surgical care that is not medically necessary or reasonable, including without limitation, care or treatment that:

(1) Is not necessary to save the life of the infant;

(2) Has a potential risk to the life or health of the infant that outweighs the potential benefit to the infant; or

(3) Is treatment that will do no more than temporarily prolong the act of dying when death is imminent.

(e)(1) A physician performing an abortion shall take all medically appropriate and reasonable steps to preserve the life and health of an infant who is born alive.

(2) If an abortion performed in a hospital results in a live birth, the attending physician shall:

(A) Provide immediate medical care to the infant;

(B) Inform the mother of the live birth; and

(C) Request transfer of the infant to an on-duty resident or emergency care physician who shall provide medically appropriate and reasonable medical care and treatment to the infant.

(3) If an abortion performed in a healthcare facility other than a hospital results in a live birth, the attending physician shall:

(A) Provide immediate medical care to the infant; and

(B) Call 911 for an emergency transfer of the infant to the hospital for medically appropriate and reasonable care and treatment for the infant.

(f) If a physician described in subsection (e) of this section is unable to perform the duties described in subsection (e) of this section because the physician is assisting the woman who received an abortion, the attending physician’s assistant, nurse, or other healthcare professional shall assume the duties outlined in subsection (e) of this section.

(g) An infant who is born alive shall be treated as an individual under the laws of this state with the same rights to medically appropriate reasonable care and treatment that an infant born prematurely would have.

(h) The infant who is born alive upon birth immediately shall become a ward of the state if:

(1) Before the abortion, the pregnant woman, or if married, the pregnant woman and her spouse, have stated in writing that they do not wish to keep the infant if the abortion results in a live birth; and

(2) The writing described in subdivision (h)(1) of this section is not retracted before the abortion.

(i)(1) An infant who is born alive shall not be used for any type of scientific research or other kind of experimentation except as necessary to protect or preserve the life and health of the infant who is born alive.

(2) A violation of subdivision (i)(1) of this section is a Class D felony.

(j) Failure to comply with this section shall provide a basis for:

(1) A civil action for compensatory and punitive damages;

(2) Professional disciplinary action by the appropriate healthcare licensing board for the suspension or revocation of a license for a healthcare professional for at least one (1) year; and

(3) Recovery for the parent of the infant or the parent or legal guardian of the pregnant woman, if the pregnant woman is a minor, for the wrongful death of the infant under § 16-62-102.

(k) This section does not:

(1) Create or recognize a right to abortion;

(2) Affect existing federal or state law regarding abortion; or

(3) Alter generally accepted medical standards.

History. Acts 2017, No. 392, § 2.

A.C.R.C. Notes. Acts 2017, No. 392, § 1, provided: "Legislative findings and purpose.

"(a) The General Assembly finds that:

"(1) The State of Arkansas has a paramount interest in protecting all human life;

"(2) If an abortion results in the live birth of an infant, the infant is a person for all purposes under the laws of this state;

"(3) It is not an infringement on a woman's right to terminate her pregnancy for this state to assert its interest in protecting an infant whose live birth occurred as a result of an abortion; and

"(4) Without proper legal protection, infants who are born alive and have survived abortions have been denied appro-

priate life-saving or life-sustaining medical care and treatment and have been left to die.

"(b) It is the purpose of this act to:

"(1) Ensure the protection and promotion of the health and well-being of all infants born alive in this state; and

"(2) Mandate that healthcare professionals give medically appropriate and reasonable life-saving and life-sustaining medical care and treatment to all infants who are born alive."

Acts 2017, No. 392, § 3, provided: "Right of intervention. The General Assembly by joint resolution may appoint one (1) or more of its members who sponsored or cosponsored this act in his or her official capacity to intervene as a matter of right in any case in which the constitutionality of this act is challenged."

SUBCHAPTER 7 — ABORTION — VIABLE FETUS

SECTION.	SECTION.
20-16-701. Legislative intent — Construction.	20-16-705. Abortion of viable fetus prohibited — Exceptions.
20-16-702. Definitions.	20-16-706. Method or technique required.
20-16-703. Presumption of viability.	20-16-707. Attendance of additional physician required.
20-16-704. Penalty.	

RESEARCH REFERENCES

ALR. Validity, construction, and application of statutes requiring parental notification of or consent to minor’s abortion. 77 A.L.R.5th 1.

Am. Jur. 1 Am. Jur. 2d, Abortion & B.C., § 1 et seq.

C.J.S. 1 C.J.S., Abortion & B.C., § 1 et seq.

U. Ark. Little Rock L.J. Legislative Survey, Health Law, 8 U. Ark. Little Rock L.J. 583.

20-16-701. Legislative intent — Construction.

- (a) It is the intention of the General Assembly to regulate abortions in a manner consistent with the decisions of the United States Supreme Court.
- (b) All provisions and all terms shall be construed so as to be consistent with those decisions.

History. Acts 1985, No. 268, § 7; A.S.A. 1947, § 41-2568.

RESEARCH REFERENCES

ALR. Women’s Reproductive Rights Concerning Abortion, and Governmental

Regulation Thereof — Supreme Court Cases. 20 A.L.R. Fed. 2d 1.

20-16-702. Definitions.

As used in this subchapter:

- (1) “Abortion” means the intentional termination of the pregnancy of a mother with an intention other than to increase the probability of a live birth or to remove a dead or dying fetus;
- (2) “Physician” means any person licensed to practice medicine in this state; and
- (3) “Viable fetus” means a fetus which can live outside the womb.

History. Acts 1985, No. 268, § 1; A.S.A. 1947, § 41-2562.

RESEARCH REFERENCES

Ark. L. Rev. Allowing Fetal Wrongful Whose Time Has Come?, 44 Ark. L. Rev. Death Actions in Arkansas: A Death 465.

20-16-703. Presumption of viability.

For the purpose of this subchapter, a fetus shall be presumed not to be viable prior to the end of the twenty-fifth week of the pregnancy.

History. Acts 1985, No. 268, § 5; A.S.A. 1947, § 41-2566.

RESEARCH REFERENCES

Ark. L. Rev. Allowing Fetal Wrongful Whose Time Has Come?, 44 Ark. L. Rev. Death Actions in Arkansas: A Death 465.

20-16-704. Penalty.

- (a) A violation of this subchapter shall be a Class A misdemeanor.
- (b) Nothing in this subchapter shall be construed to allow the charging or conviction of a woman with any criminal offense in the death of her own unborn child in utero.

History. Acts 1985, No. 268, § 6; A.S.A. 1947, § 41-2567; Acts 1999, No. 1273, § 6.

20-16-705. Abortion of viable fetus prohibited — Exceptions.

- (a) No abortion of a viable fetus shall be performed unless necessary to preserve the life or health of the woman.
- (b) Before a physician may perform an abortion upon a pregnant woman after such time as her fetus has become viable, the physician shall first certify in writing that the abortion is necessary to preserve the life or health of the woman and shall further certify in writing the medical indications for the abortion and the probable health consequences.
- (c) This subchapter shall not prohibit the abortion of a viable fetus if the pregnancy is the result of rape or incest perpetrated on a minor.

History. Acts 1985, No. 268, § 2; A.S.A. 1947, § 41-2563.

20-16-706. Method or technique required.

- (a) Any physician who performs an abortion upon a woman carrying a viable fetus shall utilize the available method or technique of abortion most likely to preserve the life and health of the viable fetus.
- (b) In cases in which the method or technique of abortion which would most likely preserve the life and health of the viable fetus would present a greater risk to the life and health of the woman than another

available method or technique, the physician may utilize the other method or technique.

(c) In all cases in which the physician performs an abortion upon a viable fetus, the physician shall certify in writing the available method or techniques considered and the reasons for choosing the method or technique employed.

History. Acts 1985, No. 268, § 3; A.S.A. 1947, § 41-2564.

20-16-707. Attendance of additional physician required.

(a) An abortion of a viable fetus shall be performed or induced only when there is in attendance a physician other than the physician performing or inducing the abortion who shall take control of and provide immediate medical care for a child born as a result of the abortion.

(b) During the performance of the abortion, the physician performing it and, subsequent to the abortion, the physician required by this section to be in attendance shall take all reasonable steps in keeping with good medical practice, consistent with the procedure used, to preserve the life and health of the viable fetus, provided that it does not pose an increased risk to the life or health of the woman.

History. Acts 1985, No. 268, § 4; A.S.A. 1947, § 41-2565.

SUBCHAPTER 8 — ABORTION — PARENTAL INVOLVEMENT ENHANCEMENT ACT

SECTION.

- 20-16-801. Title.
- 20-16-802. Legislative findings and purpose.
- 20-16-803. Definitions.
- 20-16-804. Notarized consent.
- 20-16-805. Manner of consent.
- 20-16-806. Proof of identification and relationship to pregnant woman.
- 20-16-807. Notice post-emergency.
- 20-16-808. Venue.
- 20-16-809. Judicial relief from requirement.

SECTION.

- 20-16-810. Disclosure and consent form.
- 20-16-811. Penalty.
- 20-16-812. Legislative intent.
- 20-16-813. When consent is not required.
- 20-16-814. Additional information reported by abortion providers.
- 20-16-815. Construction.
- 20-16-816. Right of intervention.
- 20-16-817. Effective date.

A.C.R.C. Notes. Acts 2015, No. 934, § 2, provided: "If any section or part of a section of this act is determined by a court to be unconstitutional, the parental notification laws under § 20-16-801 et seq., shall be revived, and to prevent a hiatus in the law, the relevant section or part of a

section of the parental notification laws shall remain in full force and effect from and after the effective date of this act notwithstanding its repeal by this act."

Publisher's Notes. This subchapter was repealed and reenacted by Acts 2015, No. 934, § 1, effective January 1, 2016.

The former subchapter, concerning Abortion – Parental Notification, was derived from the following sources:

- 20-16-801. Acts 1989, No. 270, § 1; 2005, No. 537, § 1.
- 20-16-802. Acts 1989, No. 270, § 1; 2005, No. 537, § 2.
- 20-16-803. Acts 1989, No. 270, § 1; 2005, No. 537, § 3.
- 20-16-804. Acts 1989, No. 270, § 1; 2005, No. 537, § 4.

- 20-16-805. Acts 1989, No. 270, § 1; 2005, No. 537, § 5.
- 20-16-806. Acts 1989, No. 270, § 1; 1999, No. 1273, § 7; 2005, No. 537, § 6.
- 20-16-807. Acts 1989, No. 270, § 1.
- 20-16-808. Acts 1989, No. 270, § 1; 2005, No. 537, § 7; 2009, No. 758, § 26.
- 20-16-809. Acts 2005, No. 537, § 8.
- 20-16-810. Acts 2005, No. 537, § 9.

20-16-801. Title.

This subchapter shall be known and may be cited as the “Parental Involvement Enhancement Act”.

History. Acts 2015, No. 934, § 1.

20-16-802. Legislative findings and purpose.

- (a) The General Assembly finds that:
 - (1) Immature minors often lack the ability to make fully informed choices that take into account both immediate and long-range consequences;
 - (2) The medical, emotional, and psychological consequences of abortion are sometimes serious and can be lasting, particularly when the minor is immature;
 - (3) The capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion are not necessarily related;
 - (4) Parents ordinarily possess information essential to a physician’s exercise of his or her best medical judgment concerning the minor daughter;
 - (5) Parents who are aware that their minor daughter has had an abortion may better ensure that she receives adequate medical attention after her abortion; and
 - (6) Parental consultation is usually desirable and in the best interests of the minor.
- (b) Based on the findings in subsection (a) of this section, the General Assembly’s purposes in enacting this enhancement to the State of Arkansas’s parental notice law are to further the important and compelling state interests of:
 - (1) Protecting minors against their own immaturity;
 - (2) Fostering family unity and preserving the family as a viable social unit;
 - (3) Protecting the constitutional rights of parents to rear children who are members of their household;
 - (4) Reducing teenage pregnancy and abortion; and

(5) In light of the foregoing statements of purpose, allowing for judicial bypasses of the parental notice requirement to be made only in exceptional or rare circumstances.

History. Acts 2015, No. 934, § 1.

20-16-803. Definitions.

As used in this subchapter:

(1)(A) “Abortion” means the act of using or prescribing an instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman, with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child.

(B) An act under subdivision (1)(A) of this section is not an abortion if the act is performed with the intent to:

(i) Save the life or preserve the health of the unborn child;

(ii) Remove a dead unborn child caused by spontaneous abortion; or

(iii) Remove an ectopic pregnancy;

(2) “Coercion” means restraining or dominating the choice of a pregnant woman by force, threat of force, or deprivation of food and shelter;

(3) “Consent” means:

(A) In the case of a pregnant woman who is less than eighteen (18) years of age, a notarized written statement signed by the pregnant woman and her mother, father, or legal guardian declaring that the pregnant woman intends to seek an abortion and that her mother, father, or legal guardian consents to the abortion; or

(B) In the case of a pregnant woman who is an incompetent person, a notarized written statement signed by the pregnant woman’s guardian declaring that the guardian consents to the performance of an abortion upon the pregnant woman;

(4) “Emancipated minor” means a person less than eighteen (18) years of age who is or has been married or who has been legally emancipated;

(5) “Incompetent” means a person who has been adjudged a disabled person and has had a guardian appointed for her;

(6) “Medical emergency” means a condition that, on the basis of the physician’s good-faith clinical judgment, complicates the medical condition of a pregnant woman so as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function;

(7) “Minor” means an individual under eighteen (18) years of age;

(8) “Parent” means:

(A) Either parent of the pregnant woman if both parents are living;

(B) One (1) parent of the pregnant woman if only one (1) is living or if the second parent cannot be located through reasonably diligent effort; or

(C) The court-appointed guardian or custodian if the pregnant woman has one;

(9) “Physician” means a person licensed to practice medicine in this state, including a medical doctor or a doctor of osteopathy; and

(10) “Pregnant woman” means a pregnant minor or pregnant incompetent woman.

History. Acts 2015, No. 934, § 1.

20-16-804. Notarized consent.

Except as otherwise provided in §§ 20-16-807 and 20-16-809, a physician shall not perform an abortion upon an unemancipated minor or upon a woman for whom a guardian or custodian has been appointed because of a finding of incompetency unless the physician first obtains the written consent of either parent or the legal guardian or custodian.

History. Acts 2015, No. 934, § 1.

20-16-805. Manner of consent.

(a) A physician shall not perform an abortion upon a pregnant woman unless:

(1) In the case of a woman who is less than eighteen (18) years of age, he or she obtains the notarized written consent of both the pregnant woman and one (1) of her parents or her legal guardian; or

(2) In the case of woman who is an incompetent person, the physician first obtains the notarized written consent of her legal guardian.

(b) The notarized written consent shall include without limitation the following information:

(1) The name and birthdate of the minor or incompetent woman;

(2) The name of the parent or legal guardian;

(3) A statement from the parent or legal guardian that he or she is aware that the minor or incompetent woman desires an abortion and that he or she does consent to the abortion; and

(4) The date.

History. Acts 2015, No. 934, § 1.

20-16-806. Proof of identification and relationship to pregnant woman.

(a) The physician who performs the abortion shall obtain from the parent or legal guardian entitled to consent:

(1) Positive proof of identification in the form of a valid government-issued photo identification card; and

(2) Written documentation that establishes that the parent or legal guardian is the lawful parent or legal guardian of the pregnant woman.

(b) A photocopy of the proof of identification of the parent or legal guardian and the written documentation that establishes the relation-

ship of the parent or legal guardian to the pregnant woman shall be kept in the medical file of the pregnant woman for five (5) years past the age of majority of the pregnant woman, but in no event less than seven (7) years.

(c) The physician who performs the abortion after receiving parental consent under this subchapter shall execute for inclusion in the medical record of the pregnant woman an affidavit stating the following: "I, (Insert the name of physician who performed the abortion), certify that according to my best information and belief, a reasonable person under similar circumstances would rely on the information presented by both the pregnant woman and her parent or legal guardian as sufficient evidence of identity and relationship."

History. Acts 2015, No. 934, § 1.

20-16-807. Notice post-emergency.

(a)(1) Consent is not required under this subchapter if the attending physician certifies in the medical record of the pregnant woman that a medical emergency exists and there is insufficient time to obtain the required consent.

(2) However, within twenty-four (24) hours after the completion of the abortion, the physician shall notify one (1) of the parents or the legal guardian of the minor or incompetent woman in the manner provided in this subchapter that a medical emergency abortion was performed on the pregnant woman and of the circumstances that warranted invocation of this section.

(b)(1) Unless the minor or incompetent woman gives notice of her intent to seek a judicial waiver under § 20-16-809, the physician shall verbally inform the parent or legal guardian of the minor or incompetent woman within twenty-four (24) hours after the performance of a medical emergency abortion that an abortion was performed on the minor or incompetent woman.

(2) The physician shall:

(A) Inform the parent or legal guardian of the basis for the certification of the physician required under subsection (a) of this section and provide details regarding any additional risks to the pregnant woman; and

(B) Send a written notice of the performed abortion to the last known address of the parent or legal guardian by certified mail with restricted delivery and return receipt requested.

(c) If the minor or incompetent woman gives notice to the physician of her intent to seek a judicial waiver under this subchapter, the physician shall:

(1) File a notice with a judge of a court that the minor has given notice; and

(2) Provide the information to the court that the physician would have been required to provide to the parent or legal guardian under

subsection (b) of this section if the minor or incompetent woman had not given her intent to seek a judicial waiver.

(d)(1) The court shall expeditiously schedule a confidential conference with notice to the minor or incompetent woman and the physician.

(2) If the minor or incompetent woman is able to participate in the proceedings, the court shall advise the minor or incompetent woman that she has the right to a court-appointed counsel and, upon her request, shall provide the minor or incompetent with a court-appointed counsel.

(3) If the minor or incompetent woman is unable to participate in the proceedings, the court shall appoint counsel on behalf of the minor or incompetent woman.

(e)(1) After an appropriate hearing, the court, taking into account the medical condition of the minor or incompetent woman, shall set a deadline by which the minor or incompetent woman may file a petition or motion under this subchapter.

(2) The court may subsequently extend the deadline in light of the medical condition of the minor or incompetent woman or other equitable considerations.

(3) If the minor or incompetent woman does not file a petition or motion by the deadline, either in the court or in another court with a copy filed in the original court, the court shall direct that the court clerk provide the notice to the parent or legal guardian.

History. Acts 2015, No. 934, § 1.

20-16-808. Venue.

The pregnant woman may petition a circuit court in the county in which she resides for a waiver of the consent requirement.

20-16-809. Judicial relief from requirement.

(a) The requirements and procedures of this subchapter are available to a pregnant woman regardless of whether the woman is a resident of the state.

(b) Notwithstanding the provisions of §§ 20-16-803 — 20-16-806, if a pregnant minor or incompetent woman does not wish to obtain the consent of one (1) or both parents or the guardian or custodian, then:

(1)(A) The pregnant woman may petition a circuit court for a waiver of the consent requirement and may participate in the proceedings on her own behalf.

(B) However, the court shall advise the pregnant woman that she has a right to a court-appointed counsel and, upon her request, shall provide her with such counsel.

(C) The court may appoint a guardian ad litem for the pregnant woman.

(D) A guardian ad litem appointed under this subchapter shall act to maintain the confidentiality of the proceedings;

(2)(A) When the petitioner is a minor, the petition shall include a statement that the minor is pregnant and unempancipated.

(B) The petition shall include a statement that consent has not been waived and that the pregnant woman wishes to abort the fetus without obtaining consent under this subchapter;

(3) The pregnant woman shall have the right to file her petition in the circuit court using a pseudonym or using solely her initials;

(4)(A) The court proceedings under this section shall be confidential and shall ensure the anonymity of the minor or incompetent woman.

(B) All court proceedings under this section shall be sealed and all documents related to the petition shall be confidential and shall not be available to the public;

(5) These proceedings shall be given precedence over other pending matters to the extent necessary to ensure that the court reaches a decision promptly and without delay as to serve the best interests of the pregnant minor or incompetent woman;

(6) The judge shall make in writing specific factual findings and legal conclusions supporting the decision and shall order a record of the evidence to be maintained, including the findings and conclusions of the judge;

(7)(A) An expedited confidential appeal shall be available to any pregnant minor or incompetent woman for whom the court denies an order authorizing an abortion without consent.

(B) An order authorizing an abortion without consent shall not be subject to appeal; and

(8) A filing fee shall not be required of any pregnant minor or incompetent woman at either the trial or the appellate level.

(c)(1)(A) If the court finds by clear and convincing evidence that the pregnant woman is both sufficiently mature and well-informed to decide whether to have an abortion, the court shall:

(i) Issue an order authorizing the pregnant woman to consent to the performance or inducement of an abortion without the consent of a parent or legal guardian; and

(ii) Execute the required forms.

(B) If the court does not make the findings specified in this subdivision (c)(1) or subdivision (c)(2) of this section, the court shall dismiss the petition.

(2)(A) If the court finds by clear and convincing evidence that the pregnant woman is the victim of physical or sexual abuse by one (1) or both of her parents or her legal guardian or that obtaining the consent of a parent or legal guardian is not in the best interest of the pregnant woman, the court shall issue an order authorizing the pregnant woman to consent to the performance or inducement of an abortion without the consent of a parent or guardian.

(B) If the court does not make the findings specified in subdivision (c)(1) of this section or this subdivision (c)(2), the court shall dismiss the petition.

(3) The attending physician shall report any abuse as provided in the Child Maltreatment Act, § 12-18-101 et seq.

(d)(1) If the pregnant woman claims to be mature and well-informed at a proceeding held under this subchapter, the pregnant woman shall prove by clear and convincing evidence that she is sufficiently mature and capable of giving informed consent without obtaining consent from or giving notice to her parent or legal guardian based on her experience level, perspective, and judgment.

(2) In assessing the pregnant woman's experience level, the court may consider the following relevant factors:

- (A) The age of the pregnant woman;
- (B) The pregnant woman's experiences working outside the home;
- (C) The pregnant woman's experiences living away from home;
- (D) The pregnant woman's experiences traveling on her own;
- (E) The pregnant woman's experiences handling personal finances;

(F) The pregnant woman's experiences making other significant decisions; and

(G) Other relevant factors as appropriate.

(3) In assessing the pregnant woman's perspective, the court may consider the following relevant factors:

(A) The steps that the pregnant woman took to explore her options;

(B) To what extent she considered and weighed the potential consequences of each option; and

(C) Other relevant factors as appropriate.

(4) In assessing the pregnant woman's judgment, the court may consider among other relevant factors the pregnant woman's conduct since learning of her pregnancy and her intellectual ability to understand her options and to make an informed decision.

History. Acts 2015, No. 934, § 1.

20-16-810. Disclosure and consent form.

(a) Physicians shall use a form created by the Department of Health to obtain the consent required prior to performing an abortion on a pregnant woman.

(b) A form is not valid and consent is not sufficient unless:

(1) A parent or legal guardian initials each page of the form, indicating that he or she has read and understands the information included on that page;

(2) A parent or legal guardian signs the last page of the form in front of a person who is a notary public;

(3) The pregnant woman initials each list of risks and hazards detailed in subdivision (c)(4) of this section;

(4) The pregnant woman signs a consent statement described in subdivision (c)(6) of this section; and

(5) The physician signs a physician declaration described in subdivision (c)(7) of this section.

(c) The form shall include without limitation the following information:

(1) A description of the pregnant woman's rights, including the right to informed consent as granted by the Woman's Right to Know Act of 2001, § 20-16-901 et seq. [repealed]; and the Woman's Right-to-Know Act of 2015, § 20-16-1701 et seq.;

(2) A description of the parent or legal guardian's rights under state law;

(3) A detailed description of the surgical procedures or medical procedures, or both, that are planned to be performed on the pregnant woman;

(4) A detailed list of the risks and hazards related to the surgical or medical procedures planned for the pregnant woman, including without limitation the following risks and hazards that may occur:

(A) Infection;

(B) Blood clots;

(C) Hemorrhage;

(D) Allergic reactions;

(E) A hole in the uterus or other damage to the uterus;

(F) Sterility;

(G) Injury to the bowel or bladder;

(H) Possible hysterectomy as a result of complication or injury during the procedure;

(I) Failure to remove all products of conception;

(J) Possible continuation of pregnancy;

(K) Cramping of the uterus or pelvic pain;

(L) Cervical laceration;

(M) Incompetent cervix;

(N) Emergency treatment for any complications; or

(O) Death;

(5) A description of additional information that shall be provided by the physician to the pregnant woman under state law;

(6) A consent statement signed by the pregnant woman that includes without limitation the following information individually initialed by the pregnant woman that the pregnant woman:

(A) Understands that the doctor is going to perform an abortion on her that will end her pregnancy and will result in the death of her unborn child;

(B) Is not being forced to have an abortion and that she has the choice not to have the abortion and may withdraw consent prior to the abortion;

(C) Gives permission for the procedure;

(D) Understands that there are risks and hazards that could affect her if she has the planned surgical or medical procedures;

(E) Has been given the opportunity to ask questions about her condition, alternative forms of treatment, risk of nontreatment, the procedures to be used, and the risks and hazards involved;

(F) Has been given information required by statute; and

- (G) Has sufficient information to give informed consent;
- (7) A physician declaration, signed by the physician, stating that:
 - (A) The physician or his or her assistant has, as required, explained the procedure and the contents of this form to the pregnant woman and her parent or legal guardian and has answered all questions; and
 - (B) To the best of the physician's knowledge, the patient and her parent or legal guardian have been adequately informed and have consented to the procedure;
- (8) A parental consent statement that states that the signing parent or legal guardian:
 - (A) Understands that the doctor signing the physician declaration form is going to perform an abortion on the pregnant woman, which will end her pregnancy and result in the death of her unborn child;
 - (B) Has had the opportunity to read the physician declaration form or have it read to him or her and has initialed each page;
 - (C) Had the opportunity to ask questions of the physician or the physician's assistant about the information in the physician declaration form and the surgical and medical procedures to be performed on the pregnant woman;
 - (D) Believes that he or she has sufficient information to give informed consent; and
 - (E) Affirms by the parent's or legal guardian's signature that he or she is the pregnant woman's father, mother, or legal guardian;
- (9) A page for the parent's or legal guardian's signature that shall be notarized by a notary public; and
- (10) Any additional information that may be provided to a woman under the laws of this state in order for a physician to obtain her informed consent prior to performing an abortion.

History. Acts 2015, No. 934, § 1.

20-16-811. Penalty.

- (a) The performance of an abortion in violation of this subchapter shall be a Class A misdemeanor and shall be grounds for a civil action by a person whose consent is required.
- (b) This subchapter does not allow the charging or conviction of a woman with any criminal offense in the death of her own unborn child in utero.

History. Acts 2015, No. 934, § 1.

20-16-812. Legislative intent.

This subchapter is not intended to create and shall not be construed to create an affirmative right to legal abortion.

History. Acts 2015, No. 934, § 1.

20-16-813. When consent is not required.

A minor shall not be required to obtain consent under this subchapter if the guardianship or custody order has expired or is otherwise no longer in effect.

History. Acts 2015, No. 934, § 1.

20-16-814. Additional information reported by abortion providers.

(a) In addition to other information reported by an abortion provider to the Department of Health, the following information shall be reported for each induced termination of pregnancy:

- (1) Whether parental consent was required;
- (2) Whether parental consent was obtained; and
- (3) Whether a judicial waiver was obtained.

(b) The department shall revise its forms utilized by abortion providers to report an induced termination of pregnancy by including the reporting of information required by this section.

History. Acts 2015, No. 934, § 1.

20-16-815. Construction.

(a) This subchapter does not create or recognize a right to abortion.

(b) It is not the intention of this subchapter to make lawful an abortion that is currently unlawful.

History. Acts 2015, No. 934, § 1.

20-16-816. Right of intervention.

The General Assembly, by joint resolution, may appoint one (1) or more of its members who sponsored or cosponsored this subchapter, as a matter of right and in his or her official capacity, to intervene to defend this law in any case in which its constitutionality is challenged.

History. Acts 2015, No. 934, § 1.

20-16-817. Effective date.

This subchapter takes effect on January 1, 2016.

History. Acts 2015, No. 934, § 1.

SUBCHAPTER 9 — WOMAN'S RIGHT TO KNOW ACT OF 2001

SECTION.

20-16-901 — 20-16-908. [Repealed.]

A.C.R.C. Notes. Acts 2015, No. 1086, § 1, provided: “Legislative findings and purposes.

“(a) The General Assembly finds that:

“(1) It is essential to the psychological and physical well-being of a woman who is considering an abortion that she receive complete and accurate information on abortion and its alternatives;

“(2) The knowledgeable exercise of a woman’s decision to have an abortion depends on the extent to which she receives sufficient information to make an informed choice between two (2) alternatives: giving birth or having an abortion;

“(3) Adequate and legitimate informed consent includes information which ‘relating to the consequences to the fetus’ as stated in *Planned Parenthood v. Casey*, 505 U.S. 833, 882-883 (1992);

“(4)(A) According to the Guttmacher Institute, in 2008 seventy percent (70%) of all abortions performed in the United States were performed in clinics devoted solely to providing abortions and family planning services.

“(B) Most women who seek abortions at these facilities do not:

“(i) Have any relationship with the physician who performs the abortion, before or after the procedure; or

“(ii) Return to the facility for postsurgical care.

“(C) In most instances, the woman’s only actual contact with the physician occurs simultaneously with the abortion procedure, with little opportunity to receive counseling concerning her decision;

“(5) The decision to abort a pregnancy is an important and often stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences, as stated in *Planned Parenthood v. Danforth*, 428 U.S. 52, 67 (1976);

“(6) ‘The medical, emotional, and psychological consequences of an abortion are

serious and can be lasting’, as stated in *H.L. v. Matheson*, 450 U.S. 398, 411 (1981);

“(7) Abortion facilities or providers often offer only limited or impersonal counseling opportunities; and

“(8) Many abortion facilities or providers hire untrained and unprofessional counselors to provide preabortion counseling whose primary goal is actually to sell or promote abortion services.

“(b) Based on the findings presented in subsection (a) of this section, the purposes of this act are to:

“(1) Ensure that every woman considering an abortion receives complete information on abortion and its alternatives and that every woman receiving an abortion does so only after giving her voluntary and fully informed consent to the abortion procedure;

“(2) Protect unborn children from a woman’s uninformed decision to have an abortion;

“(3) Reduce ‘the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed’, as stated in *Planned Parenthood v. Casey*, 505 U.S. 833, 882 (1992); and

“(4) Adopt the construction of the term ‘medical emergency’ accepted by the United States Supreme Court in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).”

Acts 2015, No. 1086, § 5, provided: “SAVINGS CLAUSE. If any section or part of a section of this act is determined by a court to be unconstitutional, the Woman’s Right to Know Act of 2001, § 20-16-901 et seq., shall be revived, and to prevent a hiatus in the law, the relevant section or part of a section of the Woman’s Right to Know Act of 2001 shall remain in full force and effect from and after the effective date of this act notwithstanding its repeal by this act.”

20-16-901 — 20-16-908. [Repealed.]

Publisher’s Notes. This subchapter, concerning the Woman’s Right to Know Act of 2001, was repealed by Acts 2015,

No. 1086, § 3. The subchapter was derived from the following sources:

20-16-901. Acts 2001, No. 353, § 1.

20-16-902. Acts 2001, No. 353, § 2; 2001, No. 1564, § 1.	20-16-905. Acts 2001, No. 353, § 5.
20-16-903. Acts 2001, No. 353, § 3; 2001, No. 1564, §§ 2-6; 2007, No. 1605, § 1; 2009, No. 952, § 4.	20-16-906. Acts 2001, No. 353, § 6.
20-16-904. Acts 2001, No. 353, § 4.	20-16-907. Acts 2001, No. 353, § 7.
	20-16-908. Acts 2001, No. 353, § 8; 2001, No. 1564, § 8.

SUBCHAPTER 10 — HUMAN CLONING

SECTION.

20-16-1001. Definitions.

20-16-1002. Prohibited acts — Penalties.

SECTION.

20-16-1003. Scientific research.

20-16-1004. No right of action.

20-16-1001. Definitions.

As used in this subchapter:

(1) “Asexual reproduction” means reproduction not initiated by the union of oocyte and sperm;

(2) “Embryo” means an organism of the species *Homo sapiens* from the single cell stage to eight (8) weeks of development;

(3) “Fetus” means an organism of the species *Homo sapiens* from eight (8) weeks of development until complete expulsion or extraction from a woman’s body or removal from an artificial womb or other similar environment designed to nurture the development of the organism;

(4) “Human cloning” means human asexual reproduction, accomplished by introducing the genetic material from one (1) or more human somatic cells into a fertilized or unfertilized oocyte whose nuclear material has been removed or inactivated so as to produce a living organism, at any stage of development, that is genetically virtually identical to an existing or previously existing human organism;

(5) “Oocyte” means the human female germ cell, the egg; and

(6) “Somatic cell” means a diploid cell, having a complete cell of chromosomes, obtained or derived from a living or deceased human body at any stage of development.

History. Acts 2003, No. 607, § 1.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of man Cloning, 26 U. Ark. Little Rock L. Legislation, 2003 Arkansas General As- Rev. 463.
sembly, Public Health and Welfare, Hu-

20-16-1002. Prohibited acts — Penalties.

(a) It is unlawful for any person or entity, public or private, to intentionally or knowingly:

(1) Perform or attempt to perform human cloning;

(2) Participate in an attempt to perform human cloning;

(3) Ship, transfer, or receive for any purpose an embryo produced by human cloning; or

(4) Ship, transfer, or receive, in whole or in part, any oocyte, embryo, fetus, or human somatic cell for the purpose of human cloning.

(b) A violation of subdivision (a)(1) of this section or a violation of subdivision (a)(2) of this section, or both, is a Class C felony.

(c) A violation of subdivision (a)(3) of this section or a violation of subdivision (a)(4) of this section, or both, is a Class A misdemeanor.

(d)(1) In addition to any criminal penalty that may be levied, any person or entity that violates any provision of this section shall be subject to a fine of not less than two hundred fifty thousand dollars (\$250,000) or two (2) times the amount of any pecuniary gain that is received by the person or entity, whichever is greater.

(2) All fines collected shall be placed into the general revenues of the State of Arkansas.

History. Acts 2003, No. 607, § 1.

20-16-1003. Scientific research.

(a) This subchapter does not restrict areas of scientific research not specifically prohibited by this subchapter, including research into the use of nuclear transfer or other cloning techniques to produce molecules, deoxyribonucleic acid, cells other than human embryos, tissues, organs, plants, or animals other than humans.

(b) This subchapter does not apply to in vitro fertilization, the administration of fertility-enhancing drugs, or other medical procedures used to assist a woman in becoming or remaining pregnant so long as that procedure is not specifically intended to result in the gestation or birth of a child who is genetically identical to another conceptus, embryo, fetus, or human being, living or dead.

History. Acts 2003, No. 607, § 1.

20-16-1004. No right of action.

This subchapter does not create a private right of action.

History. Acts 2003, No. 607, § 1.

SUBCHAPTER 11 — UNBORN CHILD PAIN AWARENESS AND PREVENTION ACT

SECTION.

20-16-1101. Title.

20-16-1102. Definitions.

20-16-1103. Unborn child pain awareness information.

20-16-1104. Unborn child pain prevention.

20-16-1105. Printed information.

20-16-1106. Requirements for department website.

SECTION.

20-16-1107. Procedure in case of medical emergency.

20-16-1108. Reporting.

20-16-1109. Penalties.

20-16-1110. Civil remedies.

20-16-1111. Protection of privacy in court proceedings.

20-16-1101. Title.

This subchapter shall be known and may be cited as the “Unborn Child Pain Awareness and Prevention Act”.

History. Acts 2005, No. 1696, § 1.

RESEARCH REFERENCES

ALR. Women’s Reproductive Rights Regulation Thereof — Supreme Court Concerning Abortion, and Governmental Cases. 20 A.L.R. Fed. 2d 1.

20-16-1102. Definitions.

As used in this subchapter:

(1)(A) “Abortion” means the use or prescription of any instrument, medicine, drug, or other substance or device intentionally to terminate the pregnancy of a female known to be pregnant.

(B) However, “abortion” does not include the termination of a pregnancy if the termination is intended to:

(i) Increase the probability of a live birth;

(ii) Preserve the life or health of the child after live birth; or

(iii) Remove a dead fetus who died as the result of a spontaneous miscarriage;

(2) “Attempt to perform an abortion” means an act or an omission of a statutorily required act that under the circumstances as the actor believes them to be constitutes a substantial step in a course of conduct planned to culminate in the termination of a pregnancy in this state;

(3) “Gestational age” means the age of the unborn child as calculated from the first day of the last menstrual period of the pregnant woman;

(4) “Medical emergency” means any condition that on the basis of the physician’s good-faith clinical judgment so complicates the medical condition of a pregnant female that:

(A) The immediate abortion of her pregnancy is necessary to prevent her death; or

(B) A delay will create a serious risk of substantial and irreversible impairment of a major bodily function of the pregnant female;

(5) “Physician” means a person authorized or licensed to practice medicine under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., and a person authorized to practice osteopathy under § 17-91-101 et seq.;

(6) “Probable gestational age” means the age that with reasonable probability in the judgment of a physician will be the gestational age of the unborn child at the time the abortion is planned to be performed; and

(7) “Unborn child” means a member of the species *Homo sapiens* from fertilization until birth.

History. Acts 2005, No. 1696, § 1.

20-16-1103. Unborn child pain awareness information.

Except in the case of a medical emergency:

(1) At least twenty-four (24) hours before an abortion is performed on an unborn child whose probable gestational age is twenty (20) weeks or more, the physician performing the abortion or the physician's agent shall inform the pregnant female by telephone or in person:

(A) She has the right to review the printed materials described in § 20-16-1105;

(B) These materials are available on a state-sponsored website; and

(C) What the website address is;

(2) The physician or the physician's agent shall orally inform the pregnant female that:

(A) The materials have been provided by the State of Arkansas; and

(B) They contain information on pain in relation to the unborn child;

(3) If the pregnant female chooses to view the materials other than on the website, the materials shall either:

(A) Be given to her at least twenty-four (24) hours before the abortion; or

(B) Mailed to her at least seventy-two (72) hours before the abortion by certified mail, restricted delivery to addressee, so that the postal employee may deliver the mail only to the pregnant female;

(4) If provisions are made to record or otherwise register specifically whether the female does or does not choose to have the printed materials given or mailed to her, the information required by this section may be provided by a tape recording;

(5) The pregnant female shall certify in writing before the abortion that:

(A) The information described in subdivision (1) of this section has been furnished to her; and

(B) She has been informed of her opportunity to review the printed materials described in § 20-16-1105; and

(6) Before the abortion is performed, the physician who is to perform the abortion or the physician's agent shall:

(A) Obtain a copy of the written certification required under subdivision (5) of this section; and

(B) Retain it on file with the female's medical record for at least three (3) years following the date of receipt.

History. Acts 2005, No. 1696, § 1.

Publisher's Notes. As enacted by Acts 2005, No. 1696, subdivision (3)(A) read:

“(A) Be given to her at least twenty (24) hours before the abortion; or”.

20-16-1104. Unborn child pain prevention.

(a) Except in the case of a medical emergency, before an abortion is performed on an unborn child whose gestational age is twenty (20) weeks or more, the physician performing the abortion or the physician's agent shall inform the pregnant female:

(1) Whether an anesthetic or analgesic would eliminate or alleviate organic pain to the unborn child that could be caused by the particular method of abortion to be employed; and

(2) Of the particular medical risks associated with the particular anesthetic or analgesic.

(b) After presenting the information required in subsection (a) of this section and with the consent of the pregnant female, the physician shall administer the anesthetic or analgesic.

History. Acts 2005, No. 1696, § 1.

20-16-1105. Printed information.

(a)(1)(A) The Department of Health shall publish in English and in each language that is the primary language of two percent (2%) or more of the state's population printed materials with the following statement concerning unborn children of twenty (20) weeks gestational age or more:

"By twenty (20) weeks gestation, the unborn child has the physical structures necessary to experience pain. There is evidence that by twenty (20) weeks gestation unborn children seek to evade certain stimuli in a manner that in an infant or an adult would be interpreted to be a response to pain. Anesthesia is routinely administered to unborn children who are twenty (20) weeks gestational age or more who undergo prenatal surgery."

(B) The materials shall be objective, nonjudgmental, and designed to convey only accurate scientific information about the human fetus at the various gestational ages.

(2) The department shall make the materials available on the department's website.

(3) The materials referred to in subdivision (a)(1) of this section shall be printed in a typeface large enough to be clearly legible.

(b)(1) The department's website shall be maintained at a minimum resolution of seventy-two dots per inch (72 dpi).

(2) All pictures appearing on the website shall be a minimum of two hundred by three hundred (200 X 300) pixels.

(3) All letters on the website shall be presented in a minimum of 11-point type.

(4) All information and pictures shall be accessible with an industry-standard browser that requires no additional plug-ins.

(c) Upon request, the department shall make available to any person, facility, or hospital at no cost and in appropriate numbers the materials required under this section.

History. Acts 2005, No. 1696, § 1.

20-16-1106. Requirements for department website.

(a) The Department of Health shall include on its website the information described in § 20-16-1105.

(b) No information regarding persons who use the website shall be collected or maintained.

(c) The department shall monitor the website on a daily basis to prevent and correct tampering.

History. Acts 2005, No. 1696, § 1.

20-16-1107. Procedure in case of medical emergency.

If a medical emergency compels a physician to perform an abortion, the physician shall inform the pregnant female before the abortion is performed, if possible, of the medical indications supporting the physician's judgment that:

(1) An abortion is necessary to prevent her death; or

(2) A twenty-four-hour delay will create a serious risk of substantial and irreversible impairment of a major bodily function of the pregnant female.

History. Acts 2005, No. 1696, § 1.

20-16-1108. Reporting.

(a) The Department of Health shall prepare a reporting form for physicians containing a reprint of this subchapter and listing:

(1)(A) The number of females to whom the physician or an agent of the physician provided the information described in § 20-16-1103(1).

(B) Of that number, the number provided by telephone and the number provided in person.

(C) Of each of the numbers described in this subdivision (a)(1) and subdivision (a)(2) of this section, the number provided in the capacity of:

(i) A physician who is to perform the abortion; or

(ii) An agent of the physician;

(2) The number of females who did not avail themselves of the opportunity to obtain a copy other than on the website of the printed information described in § 20-16-1105;

(3) The number who, to the best of the reporting physician's information and belief, went on to obtain the abortion;

(4) The number of abortions performed by the physician for which information otherwise required to be provided at least twenty-four (24) hours before the abortion was not so provided because an immediate abortion was necessary to prevent the female's death; and

(5) The number of abortions for which information otherwise required to be provided at least twenty-four (24) hours before the abortion information was not so provided because a delay would create serious

risk of substantial and irreversible impairment of a major bodily function of the pregnant female.

(b) The department shall ensure that copies of the reporting forms described in subsection (a) of this section are provided:

(1) Within one hundred twenty (120) days after August 12, 2005, to all physicians licensed to practice in this state;

(2) To each physician who subsequently becomes newly licensed to practice in this state, at the same time as official notification to that physician that the physician is so licensed; and

(3) By December 1 of each year after the calendar year in which this subchapter becomes effective, to all physicians licensed to practice in this state.

(c) By February 28 of each year following a calendar year in any part of which this subchapter was in effect, each physician who provided or whose agent provided information to one (1) or more females in accordance with § 20-16-1103 during the previous calendar year shall submit to the department a copy of the form described in subsection (a) of this section with the requested data entered accurately and completely.

(d)(1) For each of the items listed in subsection (a) of this section, the department shall issue by June 30 of each year a public report providing statistics compiled by the department on the basis of reports for the previous calendar year submitted in accordance with this section.

(2) Each report shall also provide the statistics for all previous calendar years, adjusted to reflect any additional information from late or corrected reports.

(3) The department shall ensure that none of the information included in the public reports could reasonably lead to the identification of any individual providing or provided information in accordance with § 20-16-1103(1) or § 20-16-1103(2).

(e) So long as reporting forms are sent to all licensed physicians in the state at least one (1) time every year and the report described in this section is issued at least one (1) time every year, the department, in order to achieve administrative convenience or fiscal savings, or to reduce the burden of reporting requirements, may:

(1) Alter any of the dates established in this section; or

(2) Consolidate the forms or reports described in this section with other forms or reports issued by the department.

(f)(1) The department shall assess against a physician who fails to submit a report required under this section within thirty (30) days after the due date a fee of five hundred dollars (\$500) for each additional thirty-day period or portion of a thirty-day period during which the report is overdue.

(2)(A) If a physician who is required to report under this section has not submitted a report or has submitted an incomplete report more than one (1) year following the due date of the report, the department may bring an action in a court of competent jurisdiction to seek an

order requiring the physician to submit a complete report within a period established by the court.

(B) Failure of the physician to file the complete report within the court-ordered period is punishable as civil contempt.

History. Acts 2005, No. 1696, § 1.

20-16-1109. Penalties.

(a) A person who knowingly or recklessly performs or attempts to perform a termination of a pregnancy in violation of this subchapter shall be subject to disciplinary action by the Arkansas State Medical Board.

(b) No penalty may be assessed against the woman upon whom the abortion is performed or attempted to be performed.

(c) No penalty or civil liability may be assessed for failure to comply with any provision of this subchapter unless the Department of Health has made the printed materials available at the time that the physician or the physician's agent is required to inform the woman of her right to review them.

History. Acts 2005, No. 1696, § 1.

20-16-1110. Civil remedies.

(a) An action seeking actual and punitive damages may be brought against a person who performed an abortion in knowing or reckless violation of this subchapter by:

(1) Any person upon whom the abortion was performed;

(2) The father of the unborn child who was the subject of the abortion; or

(3) A grandparent of the unborn child who was the subject of the abortion.

(b) Any female upon whom an abortion has been attempted in violation of this subchapter may bring an action for actual and punitive damages against a person who attempted to perform the abortion in knowing or reckless violation of this subchapter.

(c)(1) If the Department of Health fails to issue the public report required under § 20-16-1108, any group of ten (10) or more citizens of this state may seek an injunction in a court of competent jurisdiction against the Director of the Department of Health requiring that a complete report be issued within a period established by the court.

(2) Failure of the director to obey an injunction issued under subdivision (c)(1) of this section is punishable as civil contempt.

(d)(1) If judgment is rendered in favor of the plaintiff in any action described in this section, the court shall assess a reasonable attorney's fee in favor of the plaintiff against the defendant.

(2) If judgment is rendered in favor of the defendant and if the court finds that the plaintiff's suit was frivolous and brought in bad faith, the

court shall assess a reasonable attorney's fee in favor of the defendant against the plaintiff.

History. Acts 2005, No. 1696, § 1.

20-16-1111. Protection of privacy in court proceedings.

(a) In every civil or criminal action brought under this subchapter in which any female upon whom an abortion has been performed or attempted has not given her consent to disclosure of her identity, the court shall determine whether the anonymity of the female shall be preserved from public disclosure.

(b)(1) The court, upon motion or sua sponte, shall make a ruling on preserving the anonymity of the female.

(2) If the court determines that the female's anonymity should be preserved, that court shall:

(A) Issue appropriate orders to the parties, witnesses, and counsel;

(B) Direct the sealing of the record; and

(C) Order the exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard the anonymity of the female.

(3) Each order issued under subdivisions (b)(1) and (2) of this section shall be accompanied by specific written findings explaining:

(A) Why the anonymity of the female should be preserved from public disclosure;

(B) Why the order is essential to that end;

(C) Why no reasonable less restrictive alternative exists; and

(D) How the order is narrowly tailored to preserve the anonymity of the female.

(c) In the absence of written consent of the female upon whom an abortion has been performed or attempted, anyone other than a public official who brings an action under § 20-16-1110(a) shall do so under a pseudonym.

(d) This section may not be construed to conceal the identity of the plaintiff or witnesses from the defendant.

History. Acts 2005, No. 1696, § 1.

SUBCHAPTER 12 — PARTIAL-BIRTH ABORTION BAN ACT

SECTION.

20-16-1201. Title.

20-16-1202. Definitions.

20-16-1203. Partial-birth abortions prohibited — Penalty — Exemption.

20-16-1204. License suspension or revocation and fines.

SECTION.

20-16-1205. Civil liability.

20-16-1206. Hearings before the Arkansas State Medical Board.

20-16-1207. Provision for anonymity of female.

Effective Date Note. Acts 2009, No. 196, § 3: Feb. 20, 2009. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that partial-birth abortion poses serious risks to the health of a female undergoing the procedure; that those risks include, among other things: an increase in a female’s risk of suffering from cervical incompetence, a result of cervical dilation making it difficult or impossible for a female to successfully carry a subsequent pregnancy to term; an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus as a result of converting the child to a footling breech position and a risk of lacerations and secondary hemorrhaging due to the physician blindly forcing a

sharp instrument into the base of the unborn child’s skull while he or she is lodged in the birth canal, an act which could result in severe bleeding, brings with it the threat of shock, and could ultimately result in maternal death. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

20-16-1201. Title.

This subchapter shall be known and may be cited as the “Partial-Birth Abortion Ban Act”.

History. Acts 2009, No. 196, § 1.

20-16-1202. Definitions.

As used in this subchapter:

(1) “Partial-birth abortion” means an abortion in which the person performing the abortion:

(A) Purposely vaginally delivers a living human fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the female or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the female, for the purpose of performing an overt act that the person knows will kill the partially delivered living human fetus; and

(B) Performs the overt act, other than completion of delivery of a living human fetus, that kills the partially delivered living human fetus; and

(2)(A) “Physician” means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery in this state, or any other individual legally authorized by the state to perform abortions.

(B) However, any individual who is not a physician or not otherwise legally authorized by the state to perform abortions but who nevertheless directly performs a partial-birth abortion is subject to this subchapter.

History. Acts 2009, No. 196, § 1.

20-16-1203. Partial-birth abortions prohibited — Penalty — Exception.

(a)(1) Any person who knowingly performs a partial-birth abortion and thereby kills a human fetus is guilty of a Class D felony.

(2) This subsection does not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.

(b) A female upon whom a partial-birth abortion is performed shall not be prosecuted under this subchapter.

History. Acts 2009, No. 196, § 1.

20-16-1204. License suspension or revocation and fines.

(a)(1) After proper notice and an opportunity to be heard, the Arkansas State Medical Board may assess a civil fine against a physician who violates this subchapter.

(2) The civil fine shall not exceed:

(A) Twenty-five thousand dollars (\$25,000) for the first violation;

(B) Fifty thousand dollars (\$50,000) for the second violation;

(C) One hundred thousand dollars (\$100,000) for the third violation; and

(D) For each subsequent violation, any amount over one hundred thousand dollars (\$100,000) sufficient to deter future violations.

(b) The board may suspend or revoke the physician's license in accordance with procedures established under § 17-95-410.

(c)(1) All fines assessed and collected under this section shall be remitted to the Treasurer of State.

(2) The Treasurer of State shall deposit the entire amount of any fines collected under this section into the State Treasury as general revenues.

(d) The civil fine assessed under this section is in addition to the criminal penalty imposed under § 20-16-1203.

History. Acts 2009, No. 196, § 1.

20-16-1205. Civil liability.

(a) The father, if married to the mother at the time she receives a partial-birth abortion procedure, and if the mother has not attained the age of eighteen (18) years at the time of the abortion, the maternal grandparents of the fetus, may obtain appropriate relief in a civil action unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion.

(b) Relief under subsection (a) of this section shall include:

(1) Money damages for all injuries, psychological and physical, occasioned by the violation of this section; and

(2) Statutory damages equal to three (3) times the cost of the partial-birth abortion.

(c) Damages shall not be assessed against the female upon whom a partial-birth abortion is performed.

History. Acts 2009, No. 196, § 1.

20-16-1206. Hearings before the Arkansas State Medical Board.

(a) A physician accused of a violation of this subchapter may seek a hearing before the Arkansas State Medical Board to determine whether the physician's conduct was necessary to save the life of the female under § 20-16-1203.

(b) Findings from a hearing held under subsection (a) of this section are admissible at the trial of the physician on the issue of whether the physician's conduct was necessary to save the life of the female under § 20-16-1203.

(c) Upon a motion of the physician, the circuit court shall delay the beginning of the trial for not more than ninety (90) days to permit a hearing under subsection (a) of this section to take place.

History. Acts 2009, No. 196, § 1.

20-16-1207. Provision for anonymity of female.

(a) In every proceeding or action under this subchapter, the circuit court shall rule whether the anonymity of any female upon whom a partial-birth abortion is performed should be preserved from public disclosure if the female does not give her consent to the disclosure.

(b)(1) Upon its own motion or upon motion by a party to the proceeding or action under this subchapter, the circuit court shall make a ruling concerning the anonymity of any female upon whom a partial-birth abortion is performed.

(2) Upon determining that the anonymity should be preserved, the circuit court shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard the female's identity from public disclosure.

(3) Each order under subdivision (b)(2) of this section shall be accompanied by a specific written finding explaining:

(A) Why the anonymity of the female should be preserved from public disclosure;

(B) Why the order is essential to that end;

(C) How the order is narrowly tailored to serve that interest; and

(D) Why no reasonable, less restrictive alternative exists.

(c) In the absence of written consent of the female upon whom a partial-birth abortion has been performed, any person other than a public official who brings an action under this subchapter shall do so under a pseudonym.

(d) This section shall not be construed to conceal the identity of the plaintiff or of a witness from the defendant.

History. Acts 2009, No. 196, § 1.

SUBCHAPTER 13 — ARKANSAS HUMAN HEARTBEAT PROTECTION ACT

SECTION.	SECTION.
20-16-1301. Title.	20-16-1305. Exemptions — Medical personnel.
20-16-1302. Definitions.	20-16-1306. Exemptions.
20-16-1303. Testing for heartbeat.	20-16-1307. Tolling of effective date.
20-16-1304. Prohibitions.	

A.C.R.C. Notes. Acts 2015, No. 1086, § 4, provided: “The enactment and adoption of this act shall be in conjunction with and not supersede the Arkansas Human Heartbeat Protection Act, § 20-16-1301 et seq., derived from Acts 2013, No. 301.”

RESEARCH REFERENCES

Ark. L. Rev. Mark James Chaney, Recent Developments: U.S. District Court for Eastern District of Arkansas Finds Arkansas Ban on Abortions After Detection of a Heartbeat but Prior to Viability Unconstitutional but Severable from the Act’s Heartbeat Testing and Disclosure Requirements, 67 Ark. L. Rev. 509 (2014).

CASE NOTES

Constitutionality. By banning abortions after 12 weeks’ gestation, the Arkansas Human Heartbeat Protection Act, § 20-16-1301 et seq., prohibited women from making the ultimate decision to terminate a pregnancy at a point before viability. *Edwards v. Beck*, 786 F.3d 1113 (8th Cir. 2015), cert. denied, 136 S. Ct. 895, 193 L. Ed. 2d 789 (2016).

20-16-1301. Title.

This subchapter shall be known and may be cited as the “Arkansas Human Heartbeat Protection Act”.

History. Acts 2013, No. 301, § 1.

20-16-1302. Definitions.

As used in this subchapter:

- (1) “Contraceptive” means a device, drug, or chemical that prevents fertilization;
- (2) “Fetus” means the human offspring developing during pregnancy from the moment of fertilization and includes the embryonic stage of development;
- (3) “Heartbeat” means cardiac activity, the steady and repetitive rhythmic contraction of the fetal heart within the gestational sac;

(4) “Human individual” means an individual organism of the species *Homo sapiens*;

(5) “Major bodily function” includes without limitation functions of the immune system, normal cell growth, and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions;

(6) “Medical emergency” means a condition in which an abortion is necessary:

(A) To preserve the life of the pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or when continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman; or

(B) Due to the existence of a highly lethal fetal disorder as defined by the Arkansas State Medical Board;

(7) “Pregnancy” means the human female reproductive condition that begins with fertilization when the female is carrying the developing human offspring and is calculated from the first day of the last menstrual period of the human female; and

(8) “Viability” means a medical condition that begins with a detectible fetal heartbeat.

History. Acts 2013, No. 301, § 1.

20-16-1303. Testing for heartbeat.

(a) A person authorized to perform abortions under Arkansas law shall not perform an abortion on a pregnant woman before the person tests the pregnant woman to determine whether the fetus that the pregnant woman is carrying possesses a detectible heartbeat.

(b)(1) A person authorized to perform abortions under Arkansas law shall perform an abdominal ultrasound test necessary to detect a heartbeat of an unborn human individual according to standard medical practice, including the use of medical devices as determined by standard medical practice.

(2) Tests performed under subdivision (b)(1) of this section shall be approved by the Arkansas State Medical Board.

(c) The Arkansas State Medical Board shall adopt rules:

(1)(A) Based on standard medical practice for testing for the fetal heartbeat of an unborn human individual.

(B) Rules adopted under this subsection shall specify that a test for fetal heartbeat is not required in the case of a medical emergency; and

(2) To define, based on available medical evidence, the statistical probability of bringing an unborn human individual to term based on the gestational age of the unborn human individual possessing a detectible heartbeat.

(d) If a fetal heartbeat is detected during the test required under this section, the person performing the test shall inform the pregnant woman in writing:

(1) That the unborn human individual that the pregnant woman is carrying possesses a heartbeat;

(2) Of the statistical probability of bringing the unborn human individual to term based on the gestational age of the unborn human individual possessing a detectible heartbeat; and

(3) An abortion is prohibited under § 20-16-1304.

(e) If a heartbeat has been detected, the pregnant woman shall sign a form acknowledging that she has received the information required under subsection (d) of this section.

History. Acts 2013, No. 301, § 1.

CASE NOTES

Constitutionality.

Because the State made no attempt to refute the physicians' assertions of fact that a fetus was not viable until 24 weeks' gestation, was never viable at 12 weeks, and, in all normally-progressing pregnancies, had a detectable heartbeat by 12

weeks, the district court's summary judgment order enjoining enforcement of subdivision (d)(3) of this section and § 20-16-1304 had to be affirmed. *Edwards v. Beck*, 786 F.3d 1113 (8th Cir. 2015), cert. denied, 136 S. Ct. 895, 193 L. Ed. 2d 789 (2016).

20-16-1304. Prohibitions.

(a) A person authorized to perform abortions under Arkansas law shall not perform an abortion on a pregnant woman with the specific intent of causing or abetting the termination of the life of an unborn human individual whose heartbeat has been detected under § 20-16-1303 and is twelve (12) weeks or greater gestation.

(b) A violation of this section as determined by the Arkansas State Medical Board shall result in the revocation of the medical license of the person authorized to perform abortions under Arkansas law.

History. Acts 2013, No. 301, § 1.

CASE NOTES

Constitutionality.

Because the State made no attempt to refute the physicians' assertions of fact that a fetus was not viable until 24 weeks' gestation, was never viable at 12 weeks, and, in all normally-progressing pregnancies, had a detectable heartbeat by 12

weeks, the district court's summary judgment order enjoining enforcement of § 20-16-1303(d)(3) and this section had to be affirmed. *Edwards v. Beck*, 786 F.3d 1113 (8th Cir. 2015), cert. denied, 136 S. Ct. 895, 193 L. Ed. 2d 789 (2016).

20-16-1305. Exemptions — Medical personnel.

(a) A person does not violate this subchapter if the person:

- (1) Performs a medical procedure designed to or intended to prevent the death of a pregnant woman or in reasonable medical judgment to preserve the life of the pregnant woman;
- (2)(A) Has undertaken an examination for the presence of a heart-beat in the fetus utilizing standard medical practice; and
 - (B) The examination does not reveal a heartbeat; or
- (3) Has been informed by a medical professional who has undertaken the examination for fetal heartbeat that the examination did not reveal a fetal heartbeat.
- (b) This subchapter does not apply to:
 - (1) An abortion performed to save the life of the mother;
 - (2) A pregnancy that results from rape under § 5-14-103 or incest under § 5-26-202; or
 - (3) A medical emergency.

History. Acts 2013, No. 301, § 1.

20-16-1306. Exemptions.

This subchapter does not:

- (1) Subject a pregnant female on whom an abortion is performed or attempted to be performed to any criminal prosecution or civil penalty; or
- (2) Prohibit the sale, use, prescription, or administration of a measure, drug, or chemical designed for contraceptive purposes.

History. Acts 2013, No. 301, § 1.

20-16-1307. Tolling of effective date.

If a state or federal court of competent jurisdiction voids a provision of this subchapter as unconstitutional, the effective date of that provision shall be tolled until that provision has been upheld as valid by an appellate tribunal.

History. Acts 2013, No. 301, § 1.

SUBCHAPTER 14 — PAIN-CAPABLE UNBORN CHILD PROTECTION ACT

SECTION.	SECTION.
20-16-1401. Title.	20-16-1406. Reporting.
20-16-1402. Definitions.	20-16-1407. Criminal penalties.
20-16-1403. Legislative findings.	20-16-1408. Civil remedies.
20-16-1404. Determination of post-fertilization age.	20-16-1409. Protection of privacy in court proceedings.
20-16-1405. Abortion of unborn child of 20 or more weeks post-fertilization age prohibited.	20-16-1410. Construction.

Effective Dates. Acts 2013, No. 171, § 2: became law without Governor's signature Feb. 26, 2013. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that abortions of pain-capable unborn children may be legally performed today in Arkansas; that the suffering described in this act should be prohibited at the earliest possible moment; and that this act is immediately necessary because this act will ensure that no abortion of a pain-capable child will be performed in

Arkansas after this act becomes effective. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

20-16-1401. Title.

This subchapter shall be known and may be cited as the "Pain-Capable Unborn Child Protection Act".

History. Acts 2013, No. 171, § 1.

20-16-1402. Definitions.

As used in this subchapter:

(1) "Abortion" means the use or prescription of any instrument, medicine, drug, or any other substance or device:

(A) To terminate the pregnancy of a woman known to be pregnant with an intention other than to:

- (i) Increase the probability of a live birth;
- (ii) Preserve the life or health of the child after live birth; or
- (iii) Remove a dead unborn child who died as the result of natural causes in utero, accidental trauma, or a criminal assault on the pregnant woman or her unborn child; and

(B) Which causes the premature termination of the pregnancy;

(2) "Attempt to perform or induce an abortion" means an act or an omission of a statutorily required act, that under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance or induction of an abortion in this state in violation of this subchapter;

(3) "Fertilization" means the fusion of a human spermatozoon with a human ovum;

(4)(A) "Medical emergency" means a condition that, in reasonable medical judgment, so complicates the medical condition of the pregnant woman that it necessitates the immediate abortion of her pregnancy:

(i) Without first determining post-fertilization age to avert the death of the pregnant woman; or

(ii) For which the delay necessary to determine post-fertilization age will create serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions.

- (B) “Medical emergency” does not include a condition based on a claim or diagnosis that a pregnant woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function;
- (5) “Physician” means any person licensed to practice medicine and surgery or osteopathic medicine and surgery in this state;
- (6) “Post-fertilization age” means the age of the unborn child as calculated from the fertilization of the human ovum;
- (7) “Probable post-fertilization age of the unborn child” means what, in reasonable medical judgment, will, with reasonable probability, be the post-fertilization age of the unborn child at the time the abortion is planned to be performed or induced;
- (8) “Reasonable medical judgment” means a medical judgment that would be made by a reasonably prudent physician knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved;
- (9) “Unborn child” means an individual organism of the species *Homo sapiens* from fertilization until live birth; and
- (10) “Woman” means a female human being whether or not she has reached the age of majority.

History. Acts 2013, No. 171, § 1.

20-16-1403. Legislative findings.

The General Assembly finds that:

- (1) Pain receptors known as nociceptors are present throughout the unborn child’s entire body by no later than sixteen (16) weeks after fertilization, and nerves link these receptors to the brain’s thalamus and subcortical plate by no later than twenty (20) weeks;
- (2)(A) By eight (8) weeks after fertilization, the unborn child reacts to touch.
- (B) After twenty (20) weeks after fertilization, the unborn child reacts to stimuli that would be recognized as painful if applied to an adult human, for example, by recoiling;
- (3) In the unborn child, application of such painful stimuli is associated with significant increases in stress hormones known as the stress response;
- (4) Subjection to such painful stimuli is associated with long-term harmful neurodevelopmental effects, such as altered pain sensitivity and, possibly, emotional, behavioral, and learning disabilities later in life;
- (5) For the purposes of surgery on unborn children, fetal anesthesia is routinely administered and is associated with a decrease in stress hormones compared to those levels when painful stimuli are applied without such anesthesia;
- (6)(A) The position, asserted by some medical experts, that the unborn child is incapable of experiencing pain until a point later in pregnancy than twenty (20) weeks after fertilization predominately

rests on the assumption that the ability to experience pain depends on the cerebral cortex and requires nerve connections between the thalamus and the cortex.

(B) However, recent medical research and analysis, especially since 2007, provide strong evidence for the conclusion that a functioning cortex is not necessary to experience pain;

(7) Substantial evidence indicates that children born missing the bulk of the cerebral cortex, those with hydranencephaly, nevertheless experience pain;

(8) In adults, stimulation or ablation of the cerebral cortex does not alter pain perception, while stimulation or ablation of the thalamus does;

(9) Substantial evidence indicates that structures used for pain processing in early development differ from those of adults and use different neural elements available at specific times during development, such as the subcortical plate, to fulfill the role of pain processing;

(10) Consequently, there is substantial medical evidence that an unborn child is capable of experiencing pain by twenty (20) weeks after fertilization;

(11) It is the purpose of the state to assert a compelling state interest in protecting the lives of unborn children from the stage at which substantial medical evidence indicates that they are capable of feeling pain; and

(12) Mindful of *Leavitt v. Jane L.*, 518 U.S. 137 (1996), in which in the context of determining the severability of a state statute regulating abortion, the United States Supreme Court noted that an explicit statement of legislative intent specifically made applicable to a particular statute is of greater weight than a general savings or severability clause, it is the intent of the state that § 1-2-117 be specifically applied to this subchapter, and moreover the General Assembly declares that it would have passed this subchapter, and each section, subsection, subdivision, sentence, clause, phrase, or word in this subchapter, irrespective of the fact that any one (1) or more sections, subsections, subdivisions, sentences, clauses, phrases, or words, or any of their applications, were to be declared unconstitutional.

History. Acts 2013, No. 171, § 1.

20-16-1404. Determination of post-fertilization age.

(a)(1) Except in the case of a medical emergency, an abortion shall not be performed or induced or be attempted to be performed or induced unless the physician performing or inducing the abortion has first made a determination of the probable post-fertilization age of the unborn child or relied upon such a determination made by another physician.

(2) In making such a determination under subdivision (a)(1) of this section, the physician shall make such inquiries of the woman and perform or cause to be performed such medical examinations and tests as a reasonably prudent physician, knowledgeable about the case and

the medical conditions involved, would consider necessary to accurately diagnose the probable post-fertilization age of the unborn child.

(b) Any physician who purposely, knowingly, or recklessly fails to conform to any requirement of this section engages in unprofessional conduct under § 17-95-409(a)(2)(D).

History. Acts 2013, No. 171, § 1.

20-16-1405. Abortion of unborn child of 20 or more weeks post-fertilization age prohibited.

(a)(1) A person shall not perform or induce or attempt to perform or induce an abortion upon a woman when it has been determined by the physician performing or inducing or attempting to perform or induce the abortion or by another physician upon whose determination that physician relies that the probable post-fertilization age of the unborn child of the woman is twenty (20) or more weeks.

(2)(A) However, subdivision (a)(1) of this section does not apply if, in reasonable medical judgment, the pregnant woman has a condition which so complicates her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman, not including psychological or emotional conditions.

(B) A condition creating an exemption under subdivision (a)(2)(A) of this section shall not be deemed to exist if the condition is based on a claim or diagnosis that the woman will engage in conduct that she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function.

(3) Subdivision (a)(1) of this section does not apply if the pregnancy results from rape under § 5-14-103 or incest under § 5-26-202.

(b)(1) When an abortion upon a woman whose unborn child has been determined under subdivision (a)(1) of this section to have a probable post-fertilization age of twenty (20) or more weeks is not prohibited by this section, the physician shall terminate the pregnancy in the manner which, in reasonable medical judgment, provides the best opportunity for the unborn child to survive.

(2)(A) However, subdivision (b)(1) of this section does not apply if, in reasonable medical judgment, termination of the pregnancy in that manner would pose a greater risk either of the death of the pregnant woman or of the substantial and irreversible physical impairment of a major bodily function of the woman, not including psychological or emotional conditions, than would other available methods.

(B) A risk creating an exemption under subdivision (b)(2)(A) of this section shall not be deemed to exist if it is based on a claim or diagnosis that the woman will engage in conduct that she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function.

History. Acts 2013, No. 171, § 1.

20-16-1406. Reporting.

(a)(1) A physician who performs or induces or attempts to perform or induce an abortion shall report to the Department of Health on a schedule and in accordance with rules adopted by the department.

(2) The report required under subdivision (a)(1) of this section shall include without limitation:

(A) Whether a determination of probable post-fertilization age was made, the probable post-fertilization age of the unborn child determined, and the method and basis of the determination;

(B) If a determination of probable post-fertilization age of the unborn child was not made, the basis of the determination that a medical emergency existed;

(C) If the probable post-fertilization age of the unborn child was determined to be twenty (20) or more weeks, the basis of the determination that the pregnant woman had a condition which so complicated her medical condition as to necessitate the immediate abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman, not including psychological or emotional conditions;

(D) The method used for the abortion; and

(E) If an abortion was performed when the probable post-fertilization age of the unborn child was determined to be twenty (20) or more weeks:

(i) Whether the method used was one that in reasonable medical judgment provided the best opportunity for the unborn child to survive; or

(ii) If such a method under subdivision (a)(2)(E)(i) of this section was not used, the basis of the determination that termination of the pregnancy in that manner would pose a greater risk either of the death of the pregnant woman or of the substantial and irreversible physical impairment of a major bodily function of the woman, not including psychological or emotional conditions, than would other available methods.

(b)(1) By June 30 of each year the department shall issue a public report providing statistics for the previous calendar year compiled from all of the reports covering that year submitted under this section for each of the items listed in subsection (a) of this section.

(2) Each report also shall provide the statistics for all previous calendar years during which this section was in effect, adjusted to reflect any additional information from late or corrected reports.

(3) The department shall take care to ensure that none of the information included in the public reports could reasonably lead to the identification of any pregnant woman upon whom an abortion was performed or induced or attempted to be performed or induced.

(c)(1) A physician who fails to submit a report by the end of thirty (30) days after the date the report is due shall be subject to a late fee of

five hundred dollars (\$500) for each additional thirty-day period or portion of a thirty-day period the report is overdue.

(2) A physician required to report in accordance with this subchapter who has not submitted a report or has submitted only an incomplete report more than one (1) year following the date the report is due, in an action brought in the manner in which actions are brought by the department, may be directed by a court of competent jurisdiction to submit a complete report within a period stated by court order or be subject to civil contempt.

(d)(1) Purposeful, knowing, or reckless failure by a physician to conform to any requirement of this section, other than late filing of a report, constitutes unprofessional conduct under § 17-95-409.

(2) Purposeful, knowing, or reckless failure by a physician to submit a complete report in accordance with a court order constitutes unprofessional conduct under § 17-95-409.

(3) Purposeful, knowing, or reckless falsification of any report required under this section is a Class C misdemeanor.

(e) Within ninety (90) days after the effective date of this subchapter, the department shall adopt rules to assist in compliance with this section, and subdivision (a)(1) of this section shall take effect so as to require reports regarding all abortions performed or induced on or after the first day of the first calendar month following the effective date of such rules.

History. Acts 2013, No. 171, § 1.

20-16-1407. Criminal penalties.

(a) A person who purposely, knowingly, or recklessly performs or induces or attempts to perform or induce an abortion in violation of this subchapter is guilty of a Class D felony.

(b) A penalty may not be assessed against the woman upon whom the abortion is performed or induced or attempted to be performed or induced.

History. Acts 2013, No. 171, § 1.

20-16-1408. Civil remedies.

(a)(1) A woman upon whom an abortion has been performed in violation of this subchapter or the father of the unborn child who was the subject of an abortion in violation of this subchapter may bring an action against the person who purposely, knowingly, or recklessly performed or induced the abortion in violation of this subchapter for actual and punitive damages.

(2) A woman upon whom an abortion has been attempted in violation of this subchapter may bring an action against the person who attempted purposely, knowingly, or recklessly to perform or induce the abortion in violation of this subchapter for actual and punitive damages.

(b)(1) A cause of action for injunctive relief against a person who has purposely, knowingly, or recklessly violated this subchapter may be maintained by:

(A) The woman upon whom an abortion was performed or induced or attempted to be performed or induced in violation of this subchapter;

(B) A person who is the spouse, parent, sibling, or guardian of or a current or former licensed healthcare provider of the woman upon whom an abortion has been performed or induced or attempted to be performed or induced in violation of this subchapter;

(C) A prosecuting attorney with appropriate jurisdiction; or

(D) The Attorney General.

(2) The injunction shall prevent the abortion provider from performing or inducing and from attempting to perform or induce further abortions in violation of this subchapter.

(c) If judgment is rendered in favor of the plaintiff in an action described in this section, the court shall also render judgment for a reasonable attorney's fee in favor of the plaintiff against the defendant.

(d) If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall render judgment for a reasonable attorney's fee in favor of the defendant against the plaintiff.

(e) Damages or attorney's fee shall not be assessed against the woman upon whom an abortion was performed or induced or attempted to be performed or induced except under subsection (d) of this section.

History. Acts 2013, No. 171, § 1.

20-16-1409. Protection of privacy in court proceedings.

(a) In every civil or criminal proceeding or action brought under this subchapter, the court shall rule whether the anonymity of a woman upon whom an abortion has been performed or induced or attempted to be performed or induced shall be preserved from public disclosure if she does not give her consent to the disclosure.

(b) The court, upon motion or sua sponte, shall make a ruling under subsection (a) of this section and, upon determining that the woman's anonymity should be preserved, shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard the woman's identity from public disclosure.

(c) Each order under subsection (b) of this section shall be accompanied by specific written findings explaining:

(1) Why the anonymity of the woman should be preserved from public disclosure;

(2) Why the order is essential to that end;

(3) How the order is narrowly tailored to serve that interest; and

(4) Why no reasonable less restrictive alternative could be fashioned.

(d) In the absence of written consent of the woman upon whom an abortion has been performed or induced or attempted to be performed or induced, anyone other than a public official who brings an action under § 20-16-1408 shall do so under a pseudonym.

(e) This section is not intended to conceal the identity of the plaintiff or of witnesses from the defendant or from attorneys for the defendant.

History. Acts 2013, No. 171, § 1.

20-16-1410. Construction.

(a) Since it is the intent of the state to assert two (2) separate and independent compelling state interests, those in protecting the lives of viable unborn children and protecting the lives of unborn children from the stage at which substantial medical evidence indicates that they are capable of feeling pain, this subchapter does not repeal by implication or otherwise § 20-16-705.

(b) This subchapter does not repeal by implication or otherwise any other provision of this chapter.

History. Acts 2013, No. 171, § 1.

SUBCHAPTER 15 — ABORTION-INDUCING DRUGS SAFETY ACT

SECTION.	SECTION.
20-16-1501. Title.	20-16-1506. Criminal penalties.
20-16-1502. Legislative findings and purpose.	20-16-1507. Civil remedies and professional sanctions.
20-16-1503. Definitions.	20-16-1508. Construction.
20-16-1504. Unlawful distribution of abortion-inducing drug.	20-16-1509. Right of intervention.
20-16-1505. Reporting.	20-16-1510. Effective date.

20-16-1501. Title.

This subchapter may be known and cited as the “Abortion-Inducing Drugs Safety Act”.

History. Acts 2015, No. 577, § 1.

20-16-1502. Legislative findings and purpose.

(a) The General Assembly finds that:

(1) The United States Food and Drug Administration approved the drug mifepristone, a first-generation progesterone receptor modulator, as an abortion-inducing drug with a specific gestation, dosage, and administration protocol;

(2) The United States Food and Drug Administration approved mifepristone under the rubric of 21 C.F.R. § 314.520, also referred to as “Subpart H”, which is the only United States Food and Drug Administration approval process that allows for postmarketing restrictions and

provides for accelerated approval of certain drugs that are shown to be effective but “can be safely used only if distribution or use is restricted”;

(3) The United States Food and Drug Administration does not treat Subpart H drugs in the same manner as drugs that undergo the typical approval process;

(4) As approved by the United States Food and Drug Administration and as outlined in the final printed labeling of mifepristone, an abortion by mifepristone consists of three (3) two-hundred-milligram tablets of mifepristone taken orally, followed by two (2) two-hundred-microgram tablets of misoprostol taken orally, through forty-nine (49) days from the first day of the woman’s last menstrual period;

(5) The patient is to return for a follow-up visit in order to confirm that a complete termination of pregnancy has occurred;

(6) This United States Food and Drug Administration-approved protocol is referred to as the “Mifeprex regimen”;

(7) This treatment requires three (3) office visits by the patient, and the dosages may only be administered in a clinic, medical office, or hospital and under supervision of a physician;

(8) The final printed labeling of Mifeprex outlines the United States Food and Drug Administration-approved dosage and administration of both drugs in the Mifeprex regimen, namely mifepristone and misoprostol;

(9) When the United States Food and Drug Administration approved the Mifeprex regimen under Subpart H, it did so with certain restrictions such as the requirement that the distribution and use of the Mifeprex regimen must be under the supervision of a physician who has the ability to assess the duration of pregnancy, diagnose ectopic pregnancies, and provide surgical intervention or has made plans to provide surgical intervention through other qualified physicians;

(10) One (1) of the restrictions imposed by the United States Food and Drug Administration as part of its Subpart H approval is a written agreement that must be signed by both the physician and patient;

(11) In that agreement, the woman, along with the physician, attests to the following, among other statements:

(A) “I believe I am no more than 49 days (7 weeks) pregnant”;

(B) “I understand that I will take misoprostol in my provider’s office two days after I take Mifeprex (Day 3)”;

(C) “I will do the following: return to my provider’s office in 2 days (Day 3) to check if my pregnancy has ended. My provider will give me misoprostol if I am still pregnant”;

(12) The United States Food and Drug Administration concluded that available medical data did not support the safety of home use of misoprostol, and it specifically rejected information in the Mifeprex final printed labeling on self-administering misoprostol at home;

(13) Court testimony in *Planned Parenthood Cincinnati Region v. Taft*, 459 F. Supp. 2d 626 (S.D. Oh. 2006), by Planned Parenthood and other abortion providers demonstrates that providers routinely fail to follow the United States Food and Drug Administration-approved

protocol for the Mifeprex regimen as it is outlined in the Mifeprex final printed labeling and that providers are administering a single oral dose of two hundred milligrams (200 mg) of mifepristone, followed by a single vaginal or buccal dose of eight-tenths of one milligram (.8 mg) of misoprostol, through sixty-three (63) days of the woman's last menstrual period, without medical supervision and without follow-up care;

(14) The use of mifepristone presents significant medical risks to women, including without limitation abdominal pain, cramping, vomiting, headache, fatigue, uterine hemorrhage, viral infections, and pelvic inflammatory disease;

(15) Abortion-inducing drugs are associated with an increased risk of complications relative to surgical abortion, and the risk of complications increases with advancing gestational age and, in the instance of the Mifeprex regimen, with failure to complete the two-step dosage process;

(16)(A) In July 2011, the United States Food and Drug Administration reported two thousand two hundred seven (2,207) adverse events in the United States after women used the Mifeprex regimen for the termination of pregnancy.

(B) Among those were fourteen (14) deaths, six hundred twelve (612) hospitalizations, three hundred thirty-nine (339) blood transfusions, and two hundred fifty-six (256) infections, including forty-eight (48) severe infections;

(17)(A) Off-label or so-called evidence-based use of the Mifeprex regimen may be deadly.

(B) To date, fourteen (14) women have reportedly died after administration of the Mifeprex regimen, with eight (8) deaths attributed to severe bacterial infection.

(C) All eight (8) of those women administered the regimen in an off-label or evidence-based manner advocated by abortion providers.

(D) The United States Food and Drug Administration has not been able to conclude whether off-label use led to the eight (8) deaths; and

(18) Medical evidence demonstrates that women who use abortion-inducing drugs incur more complications than those who have surgical abortions.

(b) Based on the findings in subsection (a) of this section, it is the purpose of this subchapter to:

(1) Protect women from the dangerous and potentially deadly off-label use of abortion-inducing drugs such as, but not limited to, the Mifeprex regimen; and

(2) Ensure that physicians abide by the protocol tested and approved by the United States Food and Drug Administration for such abortion-inducing drugs, as outlined in the drug labels.

20-16-1503. Definitions.

As used in this subchapter:

(1)(A) "Abortion" means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman, with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child.

(B) An act under subdivision (1)(A) of this section is not an abortion if the act is performed with the intent to:

- (i) Save the life or preserve the health of the unborn child;
- (ii) Remove a dead unborn child caused by spontaneous abortion;
- (iii) Remove an ectopic pregnancy; or

(iv) Treat a maternal disease or illness for which the prescribed drug is indicated;

(2)(A) "Abortion-inducing drug" means a medicine, drug, or any other substance prescribed or dispensed with the intent of terminating the clinically diagnosable pregnancy of a woman, with knowledge that the termination will with reasonable likelihood cause the death of the unborn child.

(B) "Abortion-inducing drugs" includes off-label use of drugs known to have abortion-inducing properties, which are prescribed specifically with the intent of causing an abortion, such as misoprostol, Cytotec, and methotrexate.

(C) This definition does not apply to drugs that may be known to cause an abortion, but which are prescribed for other medical indications such as chemotherapeutic agents or diagnostic drugs.

(D) Use of drugs to induce abortion is also known as a medical, drug-induced, or chemical abortion;

(3) "Adverse event" means an undesirable experience associated with the use of a medical product in a patient, including without limitation an event that causes:

- (A) Death;
- (B) Threat to life;
- (C) Hospitalization;
- (D) Disability or permanent damage;
- (E) Congenital anomaly or birth defect, or both;
- (F) Required intervention to prevent permanent impairment or damage; or

(G) Other serious important medical events, including without limitation:

(i) Allergic bronchospasm requiring treatment in an emergency room;

(ii) Serious blood dyscrasias;

(iii) Seizures or convulsions that do not result in hospitalization; and

(iv) The development of drug dependence or drug abuse;

(4) "Final printed labeling" means the United States Food and Drug Administration-approved informational document for an abortion-in-

ducing drug that outlines the protocol authorized by the United States Food and Drug Administration and agreed upon by the drug company applying for United States Food and Drug Administration authorization of that drug;

(5) “Gestational age” means the time that has elapsed since the first day of the woman’s last menstrual period;

(6) “Mifeprex regimen” means the abortion-inducing drug regimen that involves administration of mifepristone or the brand name “Mifeprex” and misoprostol, which is the only abortion-inducing drug regimen approved by the United States Food and Drug Administration and is also known as the RU-486 regimen or simply RU-486;

(7) “Mifepristone” means the first drug used in the Mifeprex regimen;

(8) “Misoprostol” means the second drug used in the Mifeprex regimen;

(9) “Physician” means any person licensed to practice medicine in this state, including medical doctors and doctors of osteopathy; and

(10) “Unborn child” means the offspring of human beings from conception until birth.

History. Acts 2015, No. 577, § 1.

20-16-1504. Unlawful distribution of abortion-inducing drug.

(a)(1) It shall be unlawful to knowingly give, sell, dispense, administer, or otherwise provide or prescribe an abortion-inducing drug to a pregnant woman to induce an abortion or enable another person to induce an abortion unless the person who gives, sells, dispenses, administers, or otherwise provides or prescribes the abortion-inducing drug is a physician and the provision or prescription of the abortion-inducing drug satisfies the protocol authorized by the United States Food and Drug Administration, as outlined in the final printed labeling for the drug or drug regimen.

(2) In the case of the Mifeprex regimen, the final printed labeling for Mifeprex includes the United States Food and Drug Administration-approved dosage and administration instructions for both mifepristone and misoprostol.

(b) Because the failure and complication rates from medical abortion increase with advancing gestational age, because the physical symptoms of medical abortion can be identical to the symptoms of ectopic pregnancy, and because abortion-inducing drugs do not treat ectopic pregnancies but rather are contraindicated in ectopic pregnancies, the physician giving, selling, dispensing, administering, or otherwise providing or prescribing the abortion-inducing drug shall first examine the woman and document in the woman’s medical chart prior to giving, selling, dispensing, administering, or otherwise providing or prescribing the abortion-inducing drug the following information without limitation:

(1) Gestational age; and

(2) Intrauterine location of the pregnancy.

(c) Every pregnant woman to whom a physician gives, sells, dispenses, administers, or otherwise provides or prescribes any abortion-inducing drug shall be provided with a copy of the drug's label.

(d)(1) The physician who gives, sells, dispenses, administers, or otherwise provides or prescribes the abortion-inducing drug shall have a signed contract with a physician who agrees to handle complications and be able to produce that signed contract on demand by the patient or by the Department of Health.

(2) The physician who contracts to handle emergencies shall have active admitting privileges and gynecological/surgical privileges at a hospital designated to handle any emergencies associated with the use or ingestion of the abortion-inducing drug.

(3) Every pregnant woman to whom a physician gives, sells, dispenses, administers, or otherwise provides or prescribes any abortion-inducing drug shall receive the name and phone number of the contracted physician and the hospital at which that physician maintains admitting privileges and which can handle any emergencies.

(e)(1) The physician who gives, sells, dispenses, administers, or otherwise provides or prescribes any abortion-inducing drug, or an agent of the physician, shall schedule a follow-up visit for the woman for approximately fourteen (14) days after administration of the abortion-inducing drug to confirm that the pregnancy is completely terminated and to assess the degree of bleeding.

(2) The physician or agent of the physician shall make all reasonable efforts to ensure that the woman returns for the scheduled appointment.

(3) A brief description of the efforts made to comply with this subsection, including without limitation the date, time, and identification by name of the person making such efforts, shall be included in the woman's medical record.

History. Acts 2015, No. 577, § 1.

20-16-1505. Reporting.

(a) If a physician provides an abortion-inducing drug to another for the purpose of inducing an abortion as authorized in § 20-16-1504 and if the physician knows that the woman who uses the abortion-inducing drug for the purpose of inducing an abortion experiences an adverse event, the physician shall provide a written report of the adverse event within three (3) days of the event to the United States Food and Drug Administration via the MedWatch program reporting system and to the Arkansas State Medical Board.

(b)(1) The board shall compile and retain all reports it receives under this section.

(2)(A) All reports received by the board are public records open to inspection under the Freedom of Information Act of 1967, § 25-19-101 et seq.

- (B) The board shall not release to any person or entity the name or any other personal identifying information regarding a person who:
- (i) Uses an abortion-inducing drug to induce an abortion; and
 - (ii) Is the subject of a report received by the board under this section.

History. Acts 2015, No. 577, § 1.

20-16-1506. Criminal penalties.

- (a) A person who intentionally, knowingly, or recklessly violates a provision of this subchapter is guilty of a Class A misdemeanor.
- (b) A criminal penalty may not be assessed against the pregnant woman upon whom the drug-induced abortion is performed.

History. Acts 2015, No. 577, § 1.

20-16-1507. Civil remedies and professional sanctions.

- (a) In addition to whatever remedies are available under the common or statutory law of this state, failure to comply with the requirements of this subchapter shall provide a basis for:
- (1) A civil malpractice action for actual and punitive damages;
 - (2) A professional disciplinary action under § 16-114-201 et seq.; and
 - (3) Recovery for the woman's survivors for the wrongful death of the woman under § 16-62-102.
- (b) A civil liability may not be assessed against the pregnant woman upon whom the drug-induced abortion is performed.
- (c) When requested, the court shall allow a woman to proceed using solely her initials or a pseudonym and may close any proceedings in the case and enter other protective orders to preserve the privacy of the woman upon whom the drug-induced abortion was performed.
- (d) If judgment is rendered in favor of the plaintiff, the court shall also render judgment for a reasonable attorney's fee in favor of the plaintiff against the defendant.
- (e) If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for a reasonable attorney's fee in favor of the defendant against the plaintiff.

History. Acts 2015, No. 577, § 1.

20-16-1508. Construction.

- (a) This subchapter does not create or recognize a right to abortion.
- (b) It is not the intention of this subchapter to make lawful an abortion that is currently unlawful.

History. Acts 2015, No. 577, § 1.

20-16-1509. Right of intervention.

The General Assembly, by joint resolution, may appoint one (1) or more of its members who sponsored or cosponsored this subchapter in his or her official capacity to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

History. Acts 2015, No. 577, § 1.

20-16-1510. Effective date.

This subchapter takes effect on January 1, 2016.

History. Acts 2015, No. 577, § 1.

SUBCHAPTER 16 — ADVANCING WOMEN’S HEALTH ACT OF 2015

SECTION.

20-16-1601. Definitions.

20-16-1602. Awarding of public funds to entities that perform abortions prohibited.

SECTION.

20-16-1603. Construction.

A.C.R.C. Notes. Acts 2015, No. 996, § 1, provided: “Legislative findings. The General Assembly finds that:

“(1) The State of Arkansas facilitates the disbursement of both state and federal funds to qualifying entities for purposes of conducting certain activities;

“(2) Public dollars awarded to qualifying entities may facilitate or subsidize directly or indirectly expenses or activities not directly related to those for which the funds were intended, including without limitation shared administrative costs, overhead, employee salaries, rent, utilities, and various other expenses;

“(3) It is possible that public dollars made available by or through the State of Arkansas may be awarded to an entity that performs elective abortions or subsidizes or otherwise facilitates the entity’s ability to perform elective abortions although the funds were not disbursed specifically for the purpose of performing

elective abortions;

“(4) Amendment 68 to the Arkansas Constitution of 1874 states, ‘No public funds will be used to pay for any abortion, except to save the mother’s life’;

“(5) The direct or indirect subsidization or facilitation of abortion with funds distributed by the state constitutes paying for an abortion and, therefore, conflicts with Amendment 68 to the Arkansas Constitution of 1874;

“(6) As elected representatives of the people of Arkansas, the members of the General Assembly are entrusted with ensuring that all activities conducted with the aid of public funds are in accordance with the wishes of the people of Arkansas and the intent of the laws of this state; and

“(7) It is within the purview of the General Assembly to establish criteria as the basis on which public funds are disbursed.”

20-16-1601. Definitions.

As used in this subchapter:

(1)(A) “Abortion” means the act of using or prescribing an instrument, medicine, drug, device, or another substance or means with the

intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child.

(B) An act under subdivision (1)(A) of this section is not an abortion if the act is performed with the intent to:

- (i) Save the life of the mother;
- (ii) Save the life or preserve the health of the unborn child;
- (iii) Remove a dead unborn child caused by spontaneous abortion;

or

- (iv) Remove an ectopic pregnancy;

(2) "Abortion referral" means the act of recommending a pregnant woman to a doctor, clinic, or other person or entity for the purpose of obtaining or learning about obtaining an abortion;

(3) "Affiliate" means an individual or entity that, directly or indirectly, owns, controls, is controlled by, or is under the common control of another person or entity, in whole or in part, or a subsidiary, parent, or sibling entity;

(4) "Pregnancy" means the female reproductive condition of having an unborn child in the woman's uterus; and

(5) "Unborn child" means the offspring of human beings from fertilization until birth.

History. Acts 2015, No. 996, § 2.

20-16-1602. Awarding of public funds to entities that perform abortions prohibited.

(a) An agency or instrumentality of the state shall not award a grant to pay the direct or indirect costs of performing, inducing, referring, or counseling in favor of abortions, including without limitation:

- (1) Administrative costs and expenses;
- (2) Overhead costs;
- (3) Employee salaries;
- (4) Rent and mortgage payments; and
- (5) Telephone and other utility payments.

(b) An agency or instrumentality of the state shall not grant, appropriate, or distribute a grant to an individual or entity that:

(1) Performs abortions, induces abortions, provides abortion referrals, or counsels in favor of elective abortions; or

(2) Is an affiliate of a person or entity that performs abortions, induces abortions, provides abortion referrals, or counsels in favor of elective abortions.

History. Acts 2015, No. 996, § 2.

20-16-1603. Construction.

(a)(1) This subchapter does not affect the funding of a hospital, medical school, or university.

(2) The restrictions under § 20-16-1602 do not apply to funding available through the Arkansas Medicaid Program.

(b) This subchapter does not create or recognize:

(1) A right to an abortion; or

(2) A right to public funds, a contract, or a grant.

History. Acts 2015, No. 996, § 2.

SUBCHAPTER 17 — WOMAN'S RIGHT-TO-KNOW ACT

SECTION.

20-16-1701. Title.

20-16-1702. Definitions.

20-16-1703. Informed consent requirement.

20-16-1704. Publication of materials.

20-16-1705. Prevention of forced abortion — Signage in abortion facilities.

SECTION.

20-16-1706. Medical emergencies.

20-16-1707. Regulations — Collection and reporting of information.

20-16-1708. Rules.

20-16-1709. Criminal penalty.

20-16-1710. Civil penalties.

20-16-1711. Construction.

A.C.R.C. Notes. Acts 2015, No. 1086, § 1, provided: "Legislative findings and purposes.

"(a) The General Assembly finds that:

"(1) It is essential to the psychological and physical well-being of a woman who is considering an abortion that she receive complete and accurate information on abortion and its alternatives;

"(2) The knowledgeable exercise of a woman's decision to have an abortion depends on the extent to which she receives sufficient information to make an informed choice between two (2) alternatives: giving birth or having an abortion;

"(3) Adequate and legitimate informed consent includes information which 'relating to the consequences to the fetus,' as stated in *Planned Parenthood v. Casey*, 505 U.S. 833, 882-883 (1992);

"(4)(A) According to the Guttmacher Institute, in 2008 seventy percent (70%) of all abortions performed in the United States were performed in clinics devoted solely to providing abortions and family planning services.

"(B) Most women who seek abortions at these facilities do not:

"(i) Have any relationship with the physician who performs the abortion, before or after the procedure; or

"(ii) Return to the facility for postsurgical care.

"(C) In most instances, the woman's only actual contact with the physician occurs simultaneously with the abortion procedure, with little opportunity to receive counseling concerning her decision;

"(5) The decision to abort a pregnancy is an important and often stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences, as stated in *Planned Parenthood v. Danforth*, 428 U.S. 52, 67 (1976);

"(6) 'The medical, emotional, and psychological consequences of an abortion are serious and can be lasting,' as stated in *H.L. v. Matheson*, 450 U.S. 398, 411 (1981);

"(7) Abortion facilities or providers often offer only limited or impersonal counseling opportunities; and

"(8) Many abortion facilities or providers hire untrained and unprofessional counselors to provide preabortion counseling whose primary goal is actually to sell or promote abortion services.

"(b) Based on the findings presented in subsection (a) of this section, the purposes of this act are to:

"(1) Ensure that every woman considering an abortion receives complete information on abortion and its alternatives and that every woman receiving an abortion does so only after giving her volun-

tary and fully informed consent to the abortion procedure;

“(2) Protect unborn children from a woman’s uninformed decision to have an abortion;

“(3) Reduce ‘the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed’, as stated in *Planned Parenthood v. Casey*, 505 U.S. 833, 882 (1992); and

“(4) Adopt the construction of the term ‘medical emergency’ accepted by the

United States Supreme Court in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).”

Acts 2015, No. 1086, § 5, provided: “SAVINGS CLAUSE. If any section or part of a section of this act is determined by a court to be unconstitutional, the Woman’s Right to Know Act of 2001, § 20-16-901 et seq., shall be revived, and to prevent a hiatus in the law, the relevant section or part of a section of the Woman’s Right to Know Act of 2001 shall remain in full force and effect from and after the effective date of this act notwithstanding its repeal by this act.”

20-16-1701. Title.

This subchapter shall be known and may be cited as the “Woman’s Right-to-Know Act”.

History. Acts 2015, No. 1086, § 2.

20-16-1702. Definitions.

As used in this subchapter:

(1)(A) “Abortion” means the act of using or prescribing any instrument, medicine, drug, or other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child.

(B) A use, prescription, or means under this subdivision (1) is not an abortion if the use, prescription, or means is performed with the intent to:

(i) Save the life or preserve the health of the unborn child;

(ii) Remove a dead unborn child caused by spontaneous abortion;

or

(iii) Remove an ectopic pregnancy;

(2)(A) “Abortion-inducing drug” means a medicine, drug, or any other substance prescribed or dispensed with the intent of terminating the clinically diagnosable pregnancy of a woman with knowledge that the termination will with reasonable likelihood cause the death of the unborn child.

(B) “Abortion-inducing drugs” includes off-label use of drugs known to have abortion-inducing properties, which are prescribed specifically with the intent of causing an abortion, such as misoprostol, Cytotec, and methotrexate.

(C) This definition does not apply to drugs that may be known to cause an abortion but which are prescribed for other medical indications such as chemotherapeutic agents or diagnostic drugs.

(D) Use of drugs to induce abortion is also known as a medical, drug-induced, or chemical abortion;

(3) "Adverse event" means an undesirable experience associated with the use of a medical product in a patient, including without limitation an event that causes:

- (A) Death;
- (B) Threat to life;
- (C) Hospitalization;
- (D) Disability or permanent damage;
- (E) Congenital anomaly or birth defect, or both;
- (F) Required intervention to prevent permanent impairment or damage; or
- (G) Other serious important medical events, including without limitation:
 - (i) Allergic bronchospasm requiring treatment in an emergency room;
 - (ii) Serious blood dyscrasias;
 - (iii) Seizures or convulsions that do not result in hospitalization; and
 - (iv) The development of drug dependence or drug abuse;

(4) "Complication" means an adverse physical or psychological condition arising from the performance of an abortion, including without limitation:

- (A) An adverse reaction to anesthesia or other drugs;
- (B) Bleeding;
- (C) A blood clot;
- (D) Cardiac arrest;
- (E) Cervical perforation;
- (F) Coma;
- (G) Embolism;
- (H) Endometritis;
- (I) Failure to actually terminate the pregnancy;
- (J) Free fluid in the abdomen;
- (K) Hemorrhage;
- (L) Incomplete abortion, also referred to as "retained tissue";
- (M) Infection;
- (N) Metabolic disorder;
- (O) Undiagnosed ectopic pregnancy;
- (P) Placenta previa in subsequent pregnancies;
- (Q) Pelvic inflammatory disease;
- (R) A psychological or emotional complication such as depression, anxiety, or a sleeping disorder;
- (S) Preterm delivery in subsequent pregnancies;
- (T) Renal failure;
- (U) Respiratory arrest;
- (V) Shock;
- (W) Uterine perforation; and
- (X) Other adverse event;

(5) "Conception" means the fusion of a human spermatozoon with a human ovum;

(6) “Emancipated minor” means a person under eighteen (18) years of age who is or has been married or who has been legally emancipated;

(7) “Facility” means a public or private hospital, clinic, center, medical school, medical training institution, healthcare facility, physician’s office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location where medical care is provided to a person;

(8) “First trimester” means the first twelve (12) weeks of gestation;

(9) “Gestational age” means the time that has elapsed since the first day of the woman’s last menstrual period;

(10) “Hospital” means any institution licensed as a hospital pursuant to the laws of this state;

(11) “Medical emergency” means that condition which, on the basis of the physician’s good-faith clinical judgment, complicates the medical condition of a pregnant woman and necessitates the immediate termination of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function;

(12) “Physician” means any person licensed to practice medicine in this state, including medical doctors and doctors of osteopathy;

(13) “Pregnant” or “pregnancy” means that female reproductive condition of having an unborn child in the woman’s uterus;

(14) “Qualified person” means an agent of the physician who is a psychologist, licensed social worker, licensed professional counselor, registered nurse, physician assistant, or physician;

(15) “Unborn child” means the offspring of human beings from conception until birth; and

(16) “Viability” means the state of fetal development when, in the judgment of the physician based on the particular facts of the case before him or her and in light of the most advanced medical technology and information available to him or her, there is a reasonable likelihood of sustained survival of the unborn child outside the body of his or her mother, with or without artificial support.

History. Acts 2015, No. 1086, § 2.

20-16-1703. Informed consent requirement.

(a) A person shall not perform or induce an abortion without the voluntary and informed consent of the woman upon whom the abortion is to be performed or induced.

(b) Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if:

(1) At least forty-eight (48) hours before the abortion, the physician who is to perform the abortion or the referring physician has informed the woman, orally and in person, of the following:

(A) The name of the physician who will perform the abortion;

(B) Medically accurate information that a reasonable patient would consider material to the decision concerning whether or not to undergo the abortion, including:

(i) A description of the proposed abortion method;
(ii) The immediate and long-term medical risks associated with the proposed abortion method, including without limitation the risks of:

- (a) Cervical or uterine perforation;
- (b) Danger to subsequent pregnancies;
- (c) Hemorrhage; and
- (d) Infection; and

(iii) Alternatives to the abortion;

(C) The probable gestational age of the unborn child at the time the abortion is to be performed;

(D) The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed;

(E) The medical risks associated with carrying the unborn child to term;

(F) Any need for anti-Rh immune globulin therapy if the woman is Rh negative, the likely consequences of refusing such therapy, and the cost of the therapy; and

(G) Information on reversing the effects of abortion-inducing drugs;

(2) At least forty-eight (48) hours before the abortion, the physician who is to perform the abortion, the referring physician, or a qualified person informs the woman, orally and in person, that:

(A) Medical assistance benefits may be available for prenatal care, childbirth, and neonatal care and that more detailed information on the availability of such assistance is contained in the printed materials and informational DVD given to her under § 20-16-1704;

(B) The printed materials and informational DVD under § 20-16-1704 describe the unborn child and list agencies that offer alternatives to abortion;

(C)(i) The father of the unborn child is liable to assist in the support of the child, even in instances in which he has offered to pay for the abortion.

(ii) In a case of rape or incest, the information required under subdivision (b)(2)(C)(i) of this section may be omitted;

(D) The woman is free to withhold or withdraw her consent to the abortion at any time without affecting her right to future care or treatment and without the loss of any state or federally funded benefits to which she otherwise might be entitled; and

(E) The information contained in the printed materials and informational DVD given to her under § 20-16-1704 is also available on a state website;

(3)(A) The information required under subdivisions (b)(1) and (2) of this section is provided to the woman individually and in a private room to protect her privacy, to maintain the confidentiality of her

decision, to ensure that the information focuses on her individual circumstances, and to ensure that she has an adequate opportunity to ask questions.

(B) Subdivision (b)(3)(A) of this section does not preclude the provision of required information through a translator in a language understood by the woman;

(4)(A) At least forty-eight (48) hours before the abortion, the woman is given a copy of the printed materials and permitted to view and given a copy of the informational DVD under § 20-16-1704.

(B) If the woman is unable to read the materials, the materials shall be read to her in a language she can understand.

(C) If the woman asks questions concerning any of the information or materials under this subdivision (b)(4), the person who provides or reads the information or materials shall answer her questions in a language she can understand;

(5)(A) At least forty-eight (48) hours before an abortion is performed or induced on a woman whose pregnancy has progressed to twenty (20) weeks gestation or more, the physician performing the abortion on the pregnant woman, the referring physician, or a qualified person assisting the physician, orally and in person, offers information on fetal pain to the patient.

(B) The information required under subdivision (b)(5)(A) of this section and counseling related to that information shall include without limitation the following:

(i) That by twenty (20) weeks gestational age, the unborn child possesses all anatomical links in its nervous system, including spinal cord, nerve tracts, thalamus, and cortex, that are necessary in order to feel pain;

(ii) That an unborn child at twenty (20) weeks gestation or more is fully capable of experiencing pain;

(iii) A description of the actual steps in the abortion procedure to be performed or induced and at which steps in the abortion procedure the unborn child is capable of feeling pain;

(iv) That maternal anesthesia typically offers little pain prevention for the unborn child; and

(v) That an anesthetic or analgesic, or both, are available so that pain to the fetus is minimized or alleviated;

(6)(A) Before the abortion, the pregnant woman certifies in writing on a checklist form provided or approved by the Department of Health that the information required under § 20-16-1704 has been provided.

(B) A physician who performs an abortion shall report monthly to the department the total number of certifications the physician has received.

(C) The department shall make available to the public annually the number of certifications received under subdivision (b)(6)(B) of this section;

(7)(A) Except in the case of a medical emergency, the physician who is to perform the abortion receives and signs a copy of the written

certification required under subdivision (b)(6)(A) of this section before performing the abortion.

(B) The physician shall retain a copy of the checklist certification form in the pregnant woman's medical record; and

(8) At least forty-eight (48) hours before an abortion that is being performed or induced utilizing abortion-inducing drugs, the physician who is to perform the abortion, the referring physician, or a qualified person informs the pregnant woman, orally and in person, that:

(A) It may be possible to reverse the effects of the abortion if the pregnant woman changes her mind, but that time is of the essence; and

(B) Information on reversing the effects of abortion-inducing drugs is available in materials prepared by the department.

(c)(1) In the event of a medical emergency requiring an immediate termination of pregnancy, the physician who performed the abortion clearly certifies in writing the nature of the medical emergency and the circumstances that necessitated the waiving of the informed consent requirements under this subchapter.

(2) The certification required under subdivision (c)(1) of this section shall be signed by the physician who performed the emergency abortion and shall be permanently filed in both the records of the physician performing the abortion and the records of the facility where the abortion took place.

(d) A physician, facility, employee or volunteer of a facility, or any other person or entity shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the forty-eight-hour reflection period required in this section.

(e) All ultrasound images, test results, and forms signed by the patient or legal guardian shall be retained as a part of the patient's medical record and be made available for inspection by the department or other authorized agency.

History. Acts 2015, No. 1086, § 2; inserted "facility, employee or volunteer of a facility, or any other person or entity" in 2017, No. 383, § 3.

Amendments. The 2017 amendment (d).

20-16-1704. Publication of materials.

(a)(1) The Department of Health shall:

(A) Publish easily comprehensible printed materials and an informational DVD in English and Spanish within ninety (90) days after July 22, 2015;

(B) Develop and maintain a secure internet website, which may be part of an existing website, to provide the information required under this subchapter; and

(C) Monitor the website on a weekly basis to prevent and correct tampering.

(2) The department shall not collect or maintain information regarding persons using the website.

(b) The department shall review and update annually, if necessary, the following printed materials and informational DVD, which shall be easily comprehensible:

(1)(A) Geographically indexed materials that inform a pregnant woman seeking an abortion of public and private agencies and services available to assist her through pregnancy, upon childbirth, and while her child is dependent, including without limitation adoption agencies.

(B) The materials shall:

(i) Include:

(a) A comprehensive list of the public and private agencies and services, a description of the services they offer, and the telephone numbers and addresses of the agencies; and

(b) The following statement: "There are many public and private agencies willing and able to help you to carry your child to term and to assist you and your child after your child is born, whether you choose to keep your child or to place her or him for adoption. The State of Arkansas strongly urges you to contact one or more of these agencies before making a final decision about abortion. The law requires that your physician or his or her agent give you the opportunity to call agencies like these before you undergo an abortion.";

(ii) Inform the pregnant woman about available medical assistance benefits for prenatal care, childbirth, and neonatal care;

(iii) Contain a toll-free, twenty-four-hour telephone number that may be called to obtain information about the agencies in the geographic area of the caller and of the services offered; and

(iv) State that:

(a) It is unlawful for any individual to coerce a woman to undergo an abortion;

(b) If a minor is denied financial support by the minor's parents, guardian, or custodian due to the minor's refusal to undergo an abortion, the minor shall be deemed emancipated for the purposes of eligibility for public assistance benefits, except that benefits may not be used to obtain an abortion;

(c) A physician who performs an abortion upon a woman without her informed consent may be liable to her for damages in a civil action; and

(d) The law permits adoptive parents to pay costs of prenatal care, childbirth, and neonatal care.

(C) The department shall ensure that the materials described in this section are comprehensive and do not directly or indirectly promote, exclude, or discourage the use of any public or private agency or service described in this section;

(2)(A) Materials that include information on the support obligations of a father of a child who is born alive, including without limitation

the father's legal duty to support the child, including child support payments and health insurance, and the fact that paternity may be established by the father's signature on a birth certificate, by a statement of paternity, or by court action.

(B) The materials shall state that more information concerning establishment of paternity and child support services and enforcement may be obtained by calling state or county public assistance agencies;

(3)(A) Materials that describe the probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from fertilization to full term, including color photographs of the unborn child at two-week gestational increments.

(B) The materials and descriptions shall:

(i)(a) Include information about brain and heart functions, the presence of external features and internal organs during the applicable stages of development, and any relevant information on the possibility of the unborn child's survival.

(b) If a photograph is not available, a picture shall contain the dimensions of the unborn child and shall be realistic; and

(ii) Be objective, nonjudgmental, and designed to convey only accurate scientific information about the unborn child at the various gestational ages;

(4) Materials that contain objective information describing the various surgical and drug-induced methods of abortion, as well as the immediate and long-term medical risks commonly associated with each abortion method, including without limitation the risks of:

(A) Cervical or uterine perforation or rupture;

(B) Danger to subsequent pregnancies;

(C) Hemorrhage;

(D) Infection;

(E) Medical risks associated with carrying a child to term following an abortion; and

(F) Possible adverse psychological effects associated with an abortion;

(5) A uniform resource locator for the state website where the materials required under this section can be found;

(6) Materials that include information on the potential ability of a qualified person to reverse the effects of abortion-inducing drugs, such as mifepristone, Mifeprex, and misoprostol, including without limitation information directing a woman to obtain further information at appropriate websites and by contacting appropriate agencies for assistance in locating a healthcare professional to aid in the reversal of an abortion; and

(7) A checklist certification form to be used by the physician or a qualified person assisting the physician that lists the items of information to be given to the woman by a physician or the agent under this subchapter.

(c) The materials shall be printed in a typeface large enough to be clearly legible.

(d)(1) The department shall produce a standard format DVD that may be used statewide presenting the information required under this section.

(2) In preparing the DVD, the department may summarize and make reference to the comprehensive printed list of geographically indexed names and services described in this section.

(3)(A) The DVD shall show, in addition to the information described in this section, an ultrasound of the heartbeat of an unborn child at four to five (4-5) weeks gestational age, at six to eight (6-8) weeks gestational age, and each month thereafter, until viability.

(B) The information in the DVD shall be presented in an objective, unbiased manner designed to convey only accurate scientific information.

(e) The materials and the DVD required under this section shall be available at no cost from the department upon request and in appropriate number to any person, facility, or hospital.

History. Acts 2015, No. 1086, § 2.

20-16-1705. Prevention of forced abortion — Signage in abortion facilities.

(a)(1) A licensed facility where abortions are performed shall post a sign conspicuously in a location defined in subsection (b) of this section that is clearly visible to all individuals who enter and that features the text contained in subdivision (a)(2) of this section.

(2) The sign shall display the following text:

“It is against the law for anyone, regardless of his or her relationship to you, to force you to have an abortion. You have the right to contact any local or state law enforcement or any social service agency to receive protection from any actual or threatened physical, emotional, or psychological abuse. It is against the law to perform, induce, prescribe for, or provide you with the means for an abortion without your voluntary consent.”

(b) The sign shall be posted in each waiting room, patient consultation room, and procedure room used by patients for whom abortions are performed, induced, prescribed or for whom the means for an abortion are provided.

(c) The continued posting of signage shall be a condition of licensure of any facility that performs or induces abortions.

(d) The display of signage does not discharge the duty of a facility to have a physician orally inform a pregnant woman of information and materials contained in § 20-16-1703.

(e)(1) The Department of Health shall provide all signs required by this section to the licensed abortion facility.

(2) The department may require that a licensed abortion facility reimburse the department for any costs associated with the sign or signs.

History. Acts 2015, No. 1086, § 2.

20-16-1706. Medical emergencies.

When a medical emergency compels the performance of an abortion, the physician shall inform the woman before the abortion, if possible, of the medical indications supporting the physician's judgment that an immediate abortion is necessary to avert her death or that a forty-eight-hour delay will cause substantial and irreversible impairment of a major bodily function.

History. Acts 2015, No. 1086, § 2.

20-16-1707. Regulations — Collection and reporting of information.

(a) The Department of Health shall develop and promulgate regulations regarding reporting requirements.

(b)(1) The Arkansas Center for Health Statistics of the Department of Health shall ensure that all information collected by the center regarding abortions performed in this state shall be available to the public in printed form and on a twenty-four-hour basis on the center's website.

(2) In no case shall the privacy of a patient or doctor be compromised.

(c) The information collected by the center regarding abortions performed in this state shall be continually updated.

(d)(1)(A) By June 3 of each year, the department shall issue a public report providing statistics on the number of women who were provided information and materials pursuant to this subchapter during the previous calendar year.

(B) Each report shall also provide the statistics for all previous calendar years, adjusted to reflect any additional information received after the deadline.

(2) The department shall take care to ensure that none of the information included in the public reports could reasonably lead to the identification of any individual who received information or materials in accordance with § 20-16-1703.

History. Acts 2015, No. 1086, § 2.

20-16-1708. Rules.

(a)(1) The Department of Health shall adopt rules to implement this subchapter.

(2) The department may add by rule additional examples of complications to supplement those in § 20-16-1703.

(b) The Arkansas State Medical Board shall promulgate rules to ensure that physicians who perform abortions, referring physicians, or agents of either physician comply with all the requirements of this subchapter.

History. Acts 2015, No. 1086, § 2.

20-16-1709. Criminal penalty.

A person who intentionally, knowingly, or recklessly violates this subchapter commits a Class A misdemeanor.

History. Acts 2015, No. 1086, § 2.

20-16-1710. Civil penalties.

(a) In addition to any remedies available under the common law or statutory law of this state, failure to comply with the requirements of this subchapter shall provide a basis for a:

- (1) Civil malpractice action for actual and punitive damages; and
- (2) Professional disciplinary action under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.

(b) A civil liability shall not be assessed against the woman upon whom the abortion is performed.

(c) When requested, the court shall allow a woman to proceed using solely her initials or a pseudonym and may close the proceedings in the case and enter other protective orders to preserve the privacy of the woman upon whom the abortion was performed or attempted.

(d) If judgment is rendered in favor of the plaintiff, the court shall also render judgment for a reasonable attorney’s fee in favor of the plaintiff against the defendant.

(e) If judgment is rendered in favor of the defendant and the court finds that the plaintiff’s suit was frivolous and brought in bad faith, the court shall also render judgment for a reasonable attorney’s fee in favor of the defendant against the plaintiff.

History. Acts 2015, No. 1086, § 2.

20-16-1711. Construction.

- (a) This subchapter does not create or recognize a right to abortion.
- (b) This subchapter is not intended to make lawful an abortion that is currently unlawful.

History. Acts 2015, No. 1086, § 2.

**SUBCHAPTER 18 — ARKANSAS UNBORN CHILD PROTECTION FROM
DISMEMBERMENT ABORTION ACT**

SECTION.	SECTION.
20-16-1801. Title.	20-16-1805. Criminal penalty.
20-16-1802. Definitions.	20-16-1806. Protection of privacy in court proceedings.
20-16-1803. Ban on dismemberment abortion.	20-16-1807. Construction.
20-16-1804. Civil remedies — Attorney’s fees.	

20-16-1801. Title.

This subchapter shall be known and may be cited as the “Arkansas Unborn Child Protection from Dismemberment Abortion Act”.

History. Acts 2017, No. 45, § 1.

20-16-1802. Definitions.

As used in this subchapter:

(1) “Abortion” means the use or prescription of any instrument, medicine, drug, or any other substance or device:

(A) To terminate the pregnancy of a woman known to be pregnant with an intention other than to:

(i) Increase the probability of a live birth;

(ii) Preserve the life or health of the child after live birth; or

(iii) Remove a dead unborn child who died in utero as the result of natural causes, accidental trauma, or a criminal assault on the pregnant woman or her unborn child; and

(B) Which causes the premature termination of the pregnancy;

(2) “Attempt to perform or induce an abortion” means an act or an omission of a statutorily required act, that under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance or induction of an abortion in this state in violation of this subchapter;

(3)(A)(i) “Dismemberment abortion” means an abortion performed with the purpose of causing the death of an unborn child that purposely dismembers the living unborn child and extracts one (1) piece at a time from the uterus through the use of clamps, grasping forceps, tongs, scissors, or similar instruments that, through the convergence of two (2) rigid levers, slice, crush, or grasp a portion of the body of the unborn child to cut or tear off a portion of the body of the unborn child.

(ii) “Dismemberment abortion” includes an abortion in which suction is used to extract the body of the unborn child subsequent to the dismemberment of the unborn child as described under subdivision (3)(A)(i) of this section.

(B) “Dismemberment abortion” does not include an abortion that uses suction to dismember the body parts of the unborn child into a collection container;

(4) “Physician” means any person licensed to practice medicine in this state, including a medical doctor or a doctor of osteopathy;

(5) “Purposely” means to act with purpose with respect to a material element of an offense when:

(A) If the element involves the nature of the conduct of the actor or a result of the conduct of the actor, it is the conscious object of the actor to engage in conduct of that nature or cause such a result; and

(B) If the element involves the attendant circumstances, the actor is aware of the existence of such circumstances or the actor believes or hopes that such circumstances exist;

(6)(A) “Serious health risk to the pregnant woman” means a condition that, in a reasonable medical judgment, complicates the medical condition of a pregnant woman to such an extent that the abortion of a pregnancy is necessary to avert either the death of the pregnant woman or the serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman.

(B) “Serious health risk to the pregnant woman” does not include:

(i) A psychological or emotional condition; or

(ii) A medical diagnosis that is based on a claim of the pregnant woman or on a presumption that the pregnant woman will engage in conduct that could result in her death or that could cause substantial and irreversible physical impairment of a major bodily function of the pregnant woman;

(7) “Unborn child” means an individual organism of the species *Homo sapiens* from fertilization until live birth; and

(8) “Woman” means a female human being whether or not she has reached the age of majority.

History. Acts 2017, No. 45, § 1.

20-16-1803. Ban on dismemberment abortion.

(a) A person shall not purposely perform or attempt to perform a dismemberment abortion and thereby kill an unborn child unless it is necessary to prevent a serious health risk to the pregnant woman.

(b)(1) A person who is accused of violating subsection (a) of this section may seek a hearing before the Arkansas State Medical Board regarding whether the dismemberment abortion was necessary to prevent a serious health risk to the pregnant woman.

(2) The findings of the board are admissible in any court proceedings under this subchapter.

(3) Upon a motion by the person who is accused of violating subsection (a) of this section, a court shall delay the beginning of a trial for no more than thirty (30) days to permit a hearing under subdivision (b)(1) of this section.

(c) The following individuals are excluded from liability under this subchapter:

(1) A woman who receives or attempts to receive a dismemberment abortion;

(2) A nurse, technician, secretary, receptionist, or other employee or agent who is not a physician but acts at the direction of a physician; and

(3) A pharmacist or other individual who is not a physician but who fills a prescription or provides instruments or materials used in a dismemberment abortion to the physician or at the direction of the physician.

(d) This subchapter does not prohibit an abortion by any other method for any reason, including rape or incest.

History. Acts 2017, No. 45, § 1.

20-16-1804. Civil remedies — Attorney's fees.

(a)(1) A cause of action for injunctive relief against a person who has purposely violated this subchapter may be maintained by:

(A) The woman who receives or attempted to receive a dismemberment abortion in violation of this subchapter;

(B) A person who is the spouse, parent, or legal guardian of the woman who receives or attempted to receive a dismemberment abortion in violation of this subchapter; or

(C) A current or former licensed healthcare provider of the woman who receives or attempted to receive a dismemberment abortion in violation of this subchapter.

(2) The injunction shall prevent the abortion provider from performing or attempting to perform further dismemberment abortions in violation of this subchapter.

(b)(1) A cause of action for civil damages against a person who has purposely violated this subchapter may be maintained by:

(A) The woman who receives a dismemberment abortion in violation of this subchapter;

(B) The father of the unborn child, if the father is married to the woman at the time the dismemberment abortion was performed in violation of this subchapter; or

(C) If the woman who received a dismemberment abortion in violation of this subchapter is a minor or has died as a result of the dismemberment abortion, the parents or legal guardians of the woman who received a dismemberment abortion in violation of this subchapter.

(2) Civil damages shall not be awarded to a plaintiff if the pregnancy resulted from the criminal conduct of the plaintiff.

(3) Civil damages shall include:

(A) Monetary damages for psychological injuries and physical injuries associated with the dismemberment abortion; and

(B) Statutory damages equal to three (3) times the cost of the dismemberment abortion.

(c)(1) If judgment is rendered in favor of the plaintiff, the court shall also render judgment for a reasonable attorney's fee in favor of the plaintiff against the defendant.

(2) If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for a reasonable attorney's fee in favor of the defendant against the plaintiff.

(3) A reasonable attorney's fee shall not be assessed against the woman who received a dismemberment abortion.

History. Acts 2017, No. 45, § 1.

20-16-1805. Criminal penalty.

A person who violates § 20-16-1803(a) commits a Class D felony.

History. Acts 2017, No. 45, § 1.

20-16-1806. Protection of privacy in court proceedings.

(a) In a civil proceeding or action brought under this subchapter, the court shall determine whether the anonymity of a woman who received or attempted to receive a dismemberment abortion shall be preserved from public disclosure without her written consent.

(b)(1) Upon determining that the anonymity of a woman who received or attempted to receive a dismemberment abortion shall be preserved, the court shall issue an order to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard from public disclosure the identity of the woman who received or attempted to receive a dismemberment abortion.

(2) An order under subdivision (b)(1) of this section shall be accompanied by specific written findings explaining:

(A) Why the anonymity of the woman who received or attempted to receive a dismemberment abortion should be preserved from public disclosure;

(B) Why the order is essential to that end;

(C) How the order is narrowly tailored to serve that end; and

(D) Why no reasonable, less restrictive alternative exists.

(3) In the absence of written consent of the woman who received or attempted to receive a dismemberment abortion, anyone other than a public official who brings an action under § 20-16-1804 shall bring the action under a pseudonym.

(4) This subsection does not conceal from the defendant the identity of the plaintiff or of a witness.

History. Acts 2017, No. 45, § 1.

20-16-1807. Construction.

This subchapter does not:

(1) Create or recognize a right to abortion;

(2) Create or recognize a right to a particular method of abortion; or

(3) Make lawful an abortion that is currently unlawful under any law of this state.

History. Acts 2017, No. 45, § 1.

SUBCHAPTER 19 — SEX DISCRIMINATION BY ABORTION PROHIBITION ACT

SECTION.	SECTION.
20-16-1901. Title.	20-16-1907. Exclusion of liability for a woman who undergoes prohibited abortion.
20-16-1902. Legislative findings and purpose.	20-16-1908. Construction.
20-16-1903. Definitions.	20-16-1909. Right of intervention.
20-16-1904. Prohibition — Sex-selection abortion.	20-16-1910. Effective date.
20-16-1905. Criminal penalties.	
20-16-1906. Civil penalties and professional sanctions.	

A.C.R.C. Notes. Acts 2017, No. 733, § 2, provided: “SEVERABILITY CLAUSE. If any provision of this act or the application of this act to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application, and to this end, the provisions of this act are declared severable.”

20-16-1901. Title.

This subchapter shall be known and may be cited as the “Sex Discrimination by Abortion Prohibition Act”.

History. Acts 2017, No. 733, § 1.

20-16-1902. Legislative findings and purpose.

- (a) The General Assembly finds that:
 - (1) With regard to sex-selection abortion:
 - (A) The victims of sex-selection abortion are overwhelmingly female;
 - (B) A sex-selection abortion is used to prevent the birth of a child of an undesired sex;
 - (C) The United States, along with other countries, has petitioned the United Nations General Assembly to declare sex-selection abortion a crime against women;
 - (D) Countries such as India, Great Britain, and China have taken steps to end sex-selection abortions;
 - (E) Women are a vital part of our society and culture and possess the same fundamental human rights as men;
 - (F) The United States prohibits discrimination on the basis of sex in various areas, including employment, education, athletics, and health insurance;
 - (G) It is undesirable to have a distortion in the sex ratio within a society, particularly when there is a shortage of women; and
 - (H) Countries with high rates of male preference have experienced ill effects as a result of having an increasing population of young, unmarried men; and
 - (2) With regard to maternal health:

(A) It is undisputed that abortion risks to maternal health increase as gestation increases;

(B) The risk of death for pregnant women at eight (8) weeks' gestation is one (1) death per one million (1,000,000) and rises to:

(i) One (1) death per twenty-nine thousand (29,000) abortions between sixteen (16) and twenty (20) weeks' gestation; and

(ii) One (1) death per eleven thousand (11,000) abortions at twenty-one (21) weeks' gestation or later;

(C) A woman is thirty-five (35) times more likely to die from an abortion performed at twenty (20) weeks' gestation than she would have been had the abortion been performed in the first trimester;

(D) A woman is ninety-one (91) times more likely to die from an abortion performed at twenty-one (21) weeks' gestation or later than she would have been had the abortion been performed in the first trimester; and

(E) Because abortions performed solely based on the sex of a child are generally performed later in pregnancy, women undergoing these abortions are unnecessarily exposed to increased health risks, including an exponentially higher risk of death.

(b) Based on the findings in this section, the purpose of this subchapter is to:

(1) Ban abortions performed solely for reasons of sex-selection; and

(2) Protect women from the risks inherent in late-term abortions.

History. Acts 2017, No. 733, § 1.

20-16-1903. Definitions.

As used in this subchapter:

(1)(A) "Abortion" means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman, with knowledge that the termination by any of those means will with reasonable likelihood cause the death of the unborn child.

(B) An act under subdivision (1)(A) of this section is not an abortion if the act is performed with the intent to:

(i) Save the life or preserve the health of the unborn child;

(ii) Remove a dead unborn child caused by spontaneous abortion;

or

(iii) Remove an ectopic pregnancy;

(2) "Incompetent" means an individual who has been adjudicated as an individual with a disability and has had a guardian appointed for her;

(3) "Minor" means an individual under eighteen (18) years of age;

(4) "Physician" means a person licensed to practice medicine in this state, including a medical doctor and a doctor of osteopathy;

(5) "Sex-selection abortion" means an abortion performed solely on the basis of the sex of the unborn child;

(6) “Unborn child” means the offspring of human beings from conception until birth; and

(7) “Viability” means the state of fetal development when, in the judgment of the physician based on the particular facts of the case before him or her and in light of the most advanced medical technology and information available to him or her, there is a reasonable likelihood of sustained survival of the unborn child outside the body of the mother, with or without artificial life support.

History. Acts 2017, No. 733, § 1.

20-16-1904. Prohibition — Sex-selection abortion.

(a) A physician or other person shall not intentionally perform or attempt to perform an abortion with the knowledge that the pregnant woman is seeking the abortion solely on the basis of the sex of the unborn child.

(b) Before performing an abortion, the physician or other person who is performing the abortion shall:

(1)(A) Ask the pregnant woman if she knows the sex of the unborn child.

(B) If the pregnant woman knows the sex of the unborn child, the physician or other person who is performing the abortion shall inform the pregnant woman of the prohibition of abortion as a method of sex selection for children; and

(2)(A) Request the medical records of the pregnant woman relating directly to the entire pregnancy history of the woman.

(B) An abortion shall not be performed until reasonable time and effort is spent to obtain the medical records of the pregnant woman as described in subdivision (b)(2)(A) of this section.

(c) If this section is held invalid as applied to the period of pregnancy prior to viability, then the section shall remain applicable to the period of pregnancy subsequent to viability.

History. Acts 2017, No. 733, § 1.

20-16-1905. Criminal penalties.

A physician or other person who knowingly performs or attempts to perform an abortion prohibited by this subchapter is guilty of a Class A misdemeanor.

History. Acts 2017, No. 733, § 1.

20-16-1906. Civil penalties and professional sanctions.

(a)(1) A physician or other person who knowingly violates this subchapter is liable for damages and shall have his or her medical license suspended or revoked as applicable.

(2) The physician or other person may also be enjoined from future acts prohibited by this subchapter.

(b)(1) A woman who receives an abortion in violation of this subchapter without being informed of the prohibition of abortion as a method of sex selection for children, the parent or legal guardian of the woman if the woman is a minor who is not emancipated, or the legal guardian of the woman if the woman has been adjudicated incompetent, may commence a civil action for any reckless violation of this subchapter and may seek both actual and punitive damages.

(2) Damages may include without limitation:

(A) Money damages for all psychological and physical injuries occasioned by the violation of this subchapter; and

(B) Statutory damages equal to ten (10) times the cost of the abortion performed in violation of this subchapter.

(c) A physician or other person who performs an abortion in violation of this subchapter shall be considered to have engaged in unprofessional conduct for which his or her license to provide healthcare services in this state shall be suspended or revoked by the Arkansas State Medical Board.

(d)(1) A cause of action for injunctive relief against any physician or other person who has knowingly violated this subchapter may be maintained by:

(A) A person who is the spouse, parent, guardian, or current or former licensed healthcare provider of the woman who receives or attempts to receive an abortion in violation of this subchapter; or

(B) The Attorney General.

(2) The injunction shall prevent the physician or other person from performing further abortions in violation of this subchapter.

History. Acts 2017, No. 733, § 1.

20-16-1907. Exclusion of liability for a woman who undergoes prohibited abortion.

(a) A woman who receives or attempts to receive an abortion in violation of this subchapter shall not be prosecuted under this subchapter for conspiracy to violate this subchapter or otherwise be held criminally or civilly liable for any violation.

(b) In a criminal proceeding or action brought under this subchapter, a woman who receives or attempts to receive an abortion in violation of this subchapter is entitled to all rights, protections, and notifications afforded to crime victims.

(c)(1) In a civil proceeding or action brought under this subchapter, the anonymity of the woman who receives or attempts to receive the abortion in violation of this subchapter shall be preserved from public disclosure unless she gives her consent to disclosure.

(2) A court of competent jurisdiction, upon motion or sua sponte, shall issue orders to the parties, witnesses, and counsel and direct the sealing of the record and exclusion of the individuals from the court-

room or hearing room to the extent necessary to safeguard the identity of the woman from public disclosure.

(3) In the absence of written consent of the woman who receives or attempts to receive an abortion in violation of this subchapter, a person who initiates a proceeding or action under § 20-16-1906(b) or § 20-16-1906(d) shall do so under a pseudonym.

History. Acts 2017, No. 733, § 1.

20-16-1908. Construction.

(a) This subchapter shall not be construed as creating or recognizing a right to abortion.

(b) It is not the intention of this subchapter to make lawful an abortion that is currently unlawful.

History. Acts 2017, No. 733, § 1.

20-16-1909. Right of intervention.

The General Assembly by joint resolution may appoint one (1) or more of its members who sponsored or cosponsored this subchapter in his or her official capacity to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

History. Acts 2017, No. 733, § 1.

20-16-1910. Effective date.

This subchapter takes effect on January 1, 2018.

History. Acts 2017, No. 733, § 1.

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